BOARD OF DIRECTORS PUBLIC MEETING
Thursday 24th June 2021, commencing at 9:00am
via Microsoft Teams

AGENDA

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
STAFF STORY (9:00am-9:15am)							
1.	**21/22/55**	**9:15 (1 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**21/22/56**	**9:16 (1 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**21/22/57**	**9:17 (3 min)**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meeting held on: **Thursday 27th May 2021.**	**D**	Read minutes
4.	**21/22/58**	**9:20 (5 mins)**	**Matters Arising and Action Log.**	Chair	To discuss any matters arising from previous meetings and provide updates and review where appropriate.	**A**	Read action log
Year End Closure for 2020/21							
5.	**21/22/59**	**9:25 (30 mins)**	**Draft Annual Report and Accounts for 2020/21:** • **Ernst and Young External Audit Year-end Draft Report, 2020/21 – 'ISA260'.** • **Letter of Representations.**	E. Saunders/ J. Grinnell/ K Byrne R. Tyler R. Tyler	To approve the Trust's draft Annual Report and Accounts for 2020/2L1.	**R/D**	Report to follow Report to follow Enclosure to follow
6.	**21/22/60**	**9:55 (25 mins)**	**Committee Annual Reports 2020/21:** - **Audit and Risk**	K. Byrne	To receive the annual reports of the sub-committees that report into the Trust Board.	**A**	Read reports

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			Committee. - **Safety and Quality Assurance Committee.** - **Resource and Business Development Committee.** - **People and Wellbeing Committee.** - **Innovation Committee.**	F. Beveridge I. Quinlan C. Dove S. Arora			
7.	**21/22/61**	**10:20 (5 mins)**	**Board Self-Certification of Compliance with the Provider Licence.**	E. Saunders	To approve: • NHS Improvement Provider Licence Self-Assessment • The declarations in relation to general condition 6 and the corporate governance statement, AHSC's and Governor Training. • The declaration in relation to general condition 6 (systems for compliance with licence conditions) and service condition 7 of the provider licence (continuity of services).	**R/D**	Read report
POST COVID-19 Recovery Plan 2021/22							
8.	**21/22/62**	**10:25 (35 mins)**	• **Access and Restoration update.** • **Paediatric Accelerator Bid Summary Position.** • **Staff/Patient Safety:** - **IPC assurance.** - **Staff Safety Metrics.**	A. Bateman A Bateman B. Larru M. Swindell	To provide an update on access and restoration of services. To provide an update. To provide the Board with an update on IPC. To provide an update on staff absences and testing.	**A** **A** **A** **A**	Read report Report to follow Presentation Presentation

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
Delivery of Outstanding Care: Safe, Effective, Caring, Responsive and Well Led							
9.	**21/22/63**	**11:00 (10 mins)**	**Serious Incident Report.**	N. Askew	To provide Board assurance of compliance with external regulation, and national guidance, in respect of incident management, including duty of candour.	**A**	Read report
10.	**21/22/64**	**11:10 (10 mins)**	**Position Statement for PALS and Complaints, Q4.**	N. Askew	To receive the position statement for Q4, 2020/21.	A	Read report
11.	**21/22/65**	**11:20 (10 mins)**	**Approach to End of Life Care when there is a dispute.**	N. Murdock	To provide an update.	A	Presentation
12.	**21/22/66**	**11:30 (40 mins)**	**Corporate Report – Divisional updates:** - **Medicine.** - **Community & Mental Health.** - **Surgery.** **Cumulative Corporate Report Metrics – Top Line Indicators:** • **Quality.** • **Safety.** • **Effective/Responsive.**	 U. Das L. Cooper A Bass N. Murdock N. Askew A. Bateman	To receive a report of Trust performance for scrutiny and discussion, highlighting any critical issues.	**A**	Read report
Lunch (12:10pm-12:30pm)							
The Best People Doing Their Best Work							
13.	**21/22/67**	**12:30 (5 mins)**	**Cumulative Corporate Report Metrics – Top Line Indicators:** • **People.**	M. Swindell	To receive a report of Trust performance for scrutiny and discussion, highlighting any critical issues.	**A**	*Refer to item 12*
14.	**21/22/68**	**12:35 (10 mins)**	**Alder Hey People Plan Update.**	M. Swindell	For information and discussion.	**A**	Read report
Sustainability through Partnerships							
15.	**21/22/69**	**12:45 (10 mins)**	**Cheshire and Merseyside of NHS Mental Health, Learning**	L. Shepherd	For approval in order to provide the Chief Executive with delegated authority to sign the MoU on behalf of	**D**	This item was withdrawn

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			Disabilities and Community Services Provider Collaborative Memorandum of Understanding.		the Trust.		
16.	**21/22/70**	**12:55 (30 mins)**	**Liverpool Neonatal Partnership Update.**	A Bateman/ LNP Team	To provide an update on the developments and progress of the Liverpool Neonatal Partnership.	**A**	Presentation
Strategic Update							
17.	**21/22/71**	**13:25 (10 mins)**	**Alder Hey in the Park Campus Development update.**	D. Powell	To receive an update on key outstanding issues/risks and plans for mitigation.	**A**	Read report
Strong Foundations (Board Assurance)							
18.	**21/22/72**	**13:35 (10 mins)**	**2021/22 H2 Draft Plan:** - **Financial Update, M2 2021/22.**	J. Grinnell	To provide an overview of the position for Month 2 and the latest financial guidance.	**A**	Presentation
19.	**21/22/73**	**13:45 (5 mins)**	**Board Assurance Framework Report.**	E. Saunders	To provide assurance on how the strategic risks that threaten the achievement of the Trust's strategic plan are being proactively managed.	**A**	Read report

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20.	**21/22/74**	**13:50 (20 mins)**	**Board Assurance Committees; report by exception:** • **Audit and Risk Committee:** - **Chair's verbal update from the meeting held on the 17.6.21.** - **Approved minutes from the meeting held on the 22.4.21.** • **Resources and Business Development Committee:** - **Chair's verbal update from the meeting held on the 21.6.21.** - **Approved minutes from the meeting held on the 24.5.21.** • **Safety and Quality Assurance Committee:** - **Chair's verbal update from the meeting held on the 23.6.21** - **Approved minutes from the meeting held on the 19.5.21.** • **Innovation Committee:** - **Chair's verbal update from the meeting held on the 14.6.21.** - **Approved minutes from the meeting held on the 19.4.21.**	K. Byrne I Quinlan F. Beveridge S. Arora	To escalate any key risks, receive updates and note approved minutes.	**A**	Verbal/ read approved minutes
Items for information							

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21.	**22/22/75**	**14:10 (4 mins)**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
22.	**21/22/76**	**14:14 (1 min)**	**Review of meeting.**	All	To review the effectiveness of the meeting and agree items for communication to staff in team brief.	**N**	Verbal
Date and Time of Next Meeting: Thursday, 28th July 2021, 9:00am-1:00pm, via Microsoft Teams.							

REGISTER OF TRUST SEAL
The Trust Seal was used in May 2021: 370 – Hill Dickinson - Counterpart Lease Valedown Ltd - Alder Hey, Liverpool Innovation Park. 371 – Hill Dickinson - Lease Valdedown Ltd – Alder Hey, Liverpool Innovation Park. 372 – Hill Dickinson - Plans for Baird House – Alder Hey, Liverpool Innovation Park

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
CQC Action Plan	E. Saunders
Financial Metrics, M2, 2021/22	J. Grinnell
DIPC Monthly Exception Report	B. Larru
Cheshire and Merseyside Cancer Alliance Performance Report	A. Bateman

Alder Hey Children's NHS
NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Confirmed Minutes of the meeting held on **Thursday 27th May 2021 at 9:00am,** via Microsoft Teams

Present:	Dame Jo Williams	Chair/Non-Executive Director	(DJW)
	Mr. N. Askew	Chief Nurse	(NA)
	Mrs. S. Arora	Non-Executive Director	(SA)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Prof. F. Beveridge	Non-Executive Director	(FB)
	Mrs. K. Byrne	Non-Executive Director	(KB)
	Mr. J. Grinnell	Director of Finance/ Deputy Chief Executive	(JG)
	Mrs. A. Marsland	Non-Executive Director	(AM)
	Dr. F. Marston	Non-Executive Director	(FM)
	Dr. N. Murdock	Medical Director	(NM)
	Mr. I. Quinlan	Vice Chair/Non-Executive Director	(IQ)
	Mrs. L. Shepherd	Chief Executive	(LS)
	Mrs. M. Swindell	Director of HR & OD	(MS)
In Attendance:	Mr. A. Bass	Director of Surgery	(AB)
	Ms. L. Cooper	Director of Community Services	(LC)
	Dr. U. Das	Director of Medicine	(UD)
	Mr. M. Flannagan	Director of Communications	(MF)
	Dr. A. Hughes	Deputy Medical Director	(AH)
	Mrs. D. Jones	Director of Strategy and Partnerships	(DJ)
	Mrs. K. McKeown	Committee Administrator (minutes)	(KMC)
	Mr. D. Powell	Development Director	(DP)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Mrs. K. Warriner	Chief Digital and Information Officer	(KW)
Patient Story	Mr. A. Lawrenson	Patient	(AL)
	Dr. L. Ramasubramanian	Consultant Child and Adolescent Psychiatrist	(LR)
	Ms. K. Mawdsley	Senior Mental Health Practitioner for Sefton Specialist CAMHS	(KM)
Observing	Mr. S. Hooker	Lead Governor	(SH)
Apologies	Prof. M. Beresford	Assoc. Director of the Board	(PMB)
	Mrs. C. Dove	Non-Executive Director	(CD)
	Mrs. C. Liddy	Director of Innovation	(CL)
Item 21/22/32	Ms. J. Chamberlain	SALS Manager	(JC)
Item 21/22/42	Ms. V. Furfie	CCIO for Community and Mental Health Division	(VF)
	Ms. E. Hughes	Deputy Managing Director of Innovation	(EM)
	Mr. J. Moreton	Senior Public Health Practitioner	(JM)

Patient Story

The Chair welcomed Alex who was invited to May's Trust Board to share his story. The Chair also welcomed Dr. Lakshmi Ramasubramanian, Consultant Child and Adolescent Psychiatrist and Kathryn Mawdsley, Senior Mental Health Practitioner for Sefton Specialist CAMHS who both supported Alex during his journey with CAMHS.

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Alex provided the Board with an overview of his circumstances that resulted in his attendance at Alder Hey's Emergency Department in 2017 and being referred to Sefton CAMHS. Alex explained how he'd lost his mum, nan and sister when he was a young child and how this had affected him. Alex informed the Board that he struggled to discuss his thoughts and emotions with doctors when he was younger but advised that he is now able to do this as a result of four years of hard work with CAMHS. Alex told Board members that he is transgender and had found it really difficult to open up to friends and family about this but the support that Alex received from CAMHS helped him realise that it is important to talk about how you feel and that you can turn to people for help. Alex pointed out that he is in a much better place now and is where he wants to be. Alex still has bad days, but he understands that this is normal and is able to accept things for what they are. Alex is now able to feel whatever comes to him naturally and he takes each day as it comes.

Dr. Ramasubramanian reported that Alex had impressed her from the first day that she met him and advised that he had not allowed himself to be defined by the challenges of his childhood. Alex developed a keen interest in music - singing, writing songs and playing the guitar - which he used to express his love for his mum, whom he saw as his best friend. Dr. Ramasubramanian informed the Board that Alex is her star patient at CAMHS and that she is so proud of his progress.

Kathryn Mawdsley advised that the beginning of Alex's journey with CAMHS was exceptionally tough for him, but he has worked so hard to get where he is today. Kathryn felt that Alex is truly inspirational and pointed out how proud the team are of Alex as he is now able to talk about what has been a very difficult time.

The Board was delighted to hear a live guitar and vocal performance from Alex of one of his own compositions, which was a truly moving expression of his journey.

Lisa Cooper thanked Alex for attending Board and sharing his experiences and music with Board members. Lisa told the Board that Alex is one of the most amazing people that she has ever met and felt that he will make enormous changes in the world. The Chair endorsed everything that was said about Alex and thanked all those concerned for attending Board.

21/22/27 Welcome and Apologies

The Chair welcomed everyone to the meeting and noted the apologies that were received.

21/22/28 Declarations of Interest

The Board noted the declaration received from Fiona Marston in relation to her association with the Liverpool School of Tropical Medicine.

21/22/29 Minutes of the previous meetings held on Thursday 29th April 2021

Resolved:

The minutes from the meeting held on the 25.3.21 were agreed as an accurate record of the meeting pending a small number of amendments that would be advised of outside of the meeting.

21/22/30 Matters Arising and Action Log

Matter Arising

There were none to discuss.

Action Log

All actions will be addressed via the agenda items.

21/22/31 Covid-19 Recovery Plan 2021/22

National Paediatric Accelerator

Adam Bateman provided an overview of the National Accelerator Programme and the successful bid which will support the recovery of services for children and young people (CYP). It was reported that Alder Hey's allocation of funding is £2.75m and carries a recovery target of 120% of the 2019/20 baseline. The themes for Alder Hey's element of the bid related to workforce, mutual aid, infrastructure and innovation. From an impact perspective, the Trust is hoping to achieve additional provision in June, July and August as funding is released and patients will receive their treatment over the next six months.

The Chair queried as to whether the Trust will be able to recruit extra staff to provide the additional care and achieve targets. It was reported that it will be challenging and there may be a point at which the organisation turns to agencies to fill the gaps. The Chair confirmed that the Board will support the work that is taking place in terms of the National Accelerator Programme but felt that the Board should recognise the stretch of the set targets. Following discussion, it was agreed to provide an update on the National Paediatric Accelerator Programme during June's Trust Board.

21/22/31.1 Action: AB

Access and Restoration

The Board receive a summary of progress that has been made in restoring services between August 2020 and April 2021. The following highlights were shared with the Board:

- It was reported that the Trust has maintained a high level of restoration at 105% for outpatients and 91% for diagnostics.
- More care has been provided for children and young people in 2021 than 2019 and the organisation is starting to see a reduction in the over 52 weeks waiting figures.
- *Access to ED* – There has been a rising level of attendances to the Emergency Department (ED) which began in March 2021 and has continued to grow. This has resulted in the Trust experiencing challenges during April and May. Increasing ED attendances is an issue for the whole of the NHS which seems in large part due to patients having difficulty accessing primary care services. The Board was advised of the importance of developing an internal plan/system wide plan to alleviate some of the problems that are being experienced to enable the Trust to treat really sick patients. Following discussion, it was agreed to submit an action plan for ED and RSV in July 2021.

21/22/31.2 Action: AB

Staff/Patient Safety

IPC Assurance

The Board received an update on Infection, Prevention and Control. A number of slides were shared with the Board and the following points were highlighted:

- It was reported that the Trust has submitted information to NHSE/I in respect to IPC preparation and compliance for a busy RSV season and winter period.

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- *Staff Lateral Flow Testing* – LAMP/LFT participation was at 27% w/c 17.5.21. It was confirmed that work will take place to look into this matter prior to July's update.
- *Vaccination Rates* – 90% of staff have received their first dose of the Covid-19 vaccination and 89% of staff have received their second dose.
- All policies are compliant with national guidance.
- There has been no Covid-19 activity in the Trust.

Staff Safety Metrics

An update was provided to the Board on figures relating to staff absence. The following data was provided:

- Overall staff absence as at the 30.4.21 was 5%.
- Six members of staff are absent due to being symptomatic/tested positive for Covid-19.
- The Trust has three members of staff shielding.

Resolved:
The Board noted the updates provided under the Covid-19 Assurance Plan Progress Update.

21/22/32 Alder Hey Wellbeing Guardian

Fiona Marston and Jeanette Chamberlain submitted a presentation to the Board to introduce the role of Alder Hey's Wellbeing Guardian, to discuss the process for implementing the nine principles and the plan to progress to Phase 2. The following information was shared:

- *What is an NHS Trust Wellbeing Guardian?*
    - A Wellbeing Guardian looks at the organisation's activities from a health and wellbeing perspective.
    - Acts as a critical friend.
    - Provides oversight, assurance and support to the NHS board.
    - Allows the Board to fulfil its legal responsibilities in ensuring the health and wellbeing of its staff.
- *Wellbeing Guardian Qualities and Characteristics* – It was reported that work is taking place with the SALS team and the Deputy Director of HR to look at what the role is and how it can be integrated.
- *9 Board Principles supported by the Wellbeing Guardian.* It was pointed out that in some instances it is quite challenging to meet what is laid down in the principles therefore work will need to take place to look at how these principles are applied with a consideration of the need and use of Board time.
- *Recommended approach to implement and embed what the Wellbeing Guardian does which is laid down in three phases.* The Trust is at the point of agreeing the priority actions for the Wellbeing Guardian's role *(Phase 1*) which has to be signed off by the Board. Completion of Phase 2 and Phase 3 will ensure that health and wellbeing is fully embedded within the organisation's processes and at Board level.
- *Checklist for Phase One* – The majority of the actions on the checklist have been addressed but it is necessary to agree priority actions for the role and look at how the organisation is going to phase in the nine principles. Jeanette Chamberlain provided an overview of the current activities that are taking place to enable staff groups to submit their plans to Non-Executive Directors for review at PAWC and formal sign-off at Board in July.

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- *Compassion* – Using compassion to move from Phase 1 to Phase 2.
- Wellbeing data from surveys was shared with the Board.
- *Summary:*
  - Alder Hey Wellbeing Guardian has been appointed.
  - Small team focused on initial implementation (WBG, SALS, organisational development and HR).
  - Developing processes for working through PAWC.
  - Plan to present to the Board in July for formal approval of the action plan.

The Chair thanked Fiona Marston for agreeing to take on the role of the Wellbeing Guardian and advised that the Board is in full support of this priority for the Trust. Fiona Marston pointed out that the Trust is already doing a lot of work around staff health and wellbeing and felt that SALS is something that should be shared with the North West Network to explain to others what Alder Hey has done.

Resolved:
The Board received and noted the presentation on Alder Hey's Health and Wellbeing Guardian.

21/22/33 Draft Annual Operational Plan

A number of slides were shared with the Board to provide an overview of the 2021/22 Annual Operational Plan. The following information was shared:

- The six priorities included in the 2021/22 NHS national planning guidance that was received:
  - Health and wellbeing of staff; recruitment and retention.
  - Covid-19 vaccination and care of patients with Covid-19.
  - Recover elective and cancer care; manage increasing demand on mental health services.
  - Expanding primary care capacity to improve access, local health outcomes and address health inequalities.
  - Transforming community and urgent and emergency care.
  - Working collaboratively across the systems to deliver on these priorities.
- Revised approach to planning:
  - The leading role of Integrated Care Systems.
  - Incentive funding (elective recovery fund) for providers but adjusted for ICS performance.
  - No provider narrative.
  - Formal submission of finance and activity for the first half of the year plan (H1) only.
- The Trust's plan for 2021/22:
  - Focus on access and safety.
  - Focus on outstanding care.
  - Focus on staff and being the best place to work.
  - Partnerships and prevention.
  - Game Changing Research and Innovation.
  - The Brilliant Basics Programme has focussed on seven measurable priorities which is to eradicate the backlog of patients waiting for treatment, improve rates of harm, be an outstanding place to work, thinking about the Trust's role in the region, the quality of access to services, influencing networks in terms of the organisation's role as an advocate, working in partnership with other colleagues and organisations, recovery of research and expansion of research studies. There is a huge piece of work around translation in terms of innovation, for example, the ideas and the concepts put into practice in a game changing way.

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- Improving access plan:
  - Rapid recovery.
  - Step-change programme; outpatient (with virtual medicine) and day case care.
  - Investment in mental health services.
  - Mutual aid and regional PTL.
  - National accelerator programme (£2.75m of investment)
- Quality and Safety Plan*:*
  - Ward to board assurance.
  - Brilliant basics (*front line and Step Change projects*).
  - Quality improvement (*Clinical Quality Improvement programme and quality priorities*).
  - Patient Safety Strategy.
- Community and Mental Health Division 'Must Do':
  - Delivery on ambitions set out in the Mental Health Delivery Plan 2021/22.
  - Continue to deliver improvements in waiting times for children and young people waiting for care and treatment.
  - Environment and estates improvements including move into new Tier 4 unit and clinical outpatient facility.
- Division of Medicine 'Must Do':
  - Safety; HDU, Mental Health inpatient care, ED Sepsis.
  - Quality; Obesity Service, PIMS-TS, Development of Paediatric expertise in Functional Disorders.
  - Business Development; International partnerships, Paediatric Stroke Services, Radiology Outreach/commercial opportunities.
  - Transforming Emergency/Acute care; virtual ED, NHS 111 First, Paediatric Assessment Unit.
  - Care closer to home; LTV and home dialysis.
  - Early diagnosis of diabetes.
- Division of Surgical Care 'Must Do':
  - Effective safety and governance.
  - Clear the backlog and reduce waiting times.
  - Liverpool Neonatal Partnership.
  - AlderC@re.
- Staff Plan:
  - Looking after staff and helping them to recover.
  - Belonging in the NHS and addressing inequalities.
  - Embed new ways of working and delivering care.
  - Grow for the future.
- Collaboration and Partnerships (*Cheshire and Merseyside CYP Transformation Programme)*:
  - Alder Hey's role.
  - Priority themes.
  - 2021/22 activity.
  - System relationships.
- Collaboration and Partnerships (*Starting Well; partnered with Starting Well research – LHP*):
  - Alder Hey's role.
  - City Plan priorities.
  - 2021/22 activity.
  - System relationships.
- Addressing health inequalities; it was felt that the development of a Health Inequalities Action Plan should be delivered via a steering group with a focus on all of the priorities set out in the slide.
- H1 Finance Plan

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John Grinnell recapped on the components of the central funding for H1 and advised that a final settled position had been received on the 24.5.21 across Cheshire and Merseyside. It was pointed out that the overarching principle of the plan is that every organisation within the system has got to achieve a breakeven position and this is the core principle that is being applied.

The Board was advised of the likely breakeven position for H1 for the Trust. Attention was drawn to the key changes that have occurred over the last week that include an assumption that Alder Hey will receive an income of around £4m of contributions from the ERF as a result of overachievement in terms of recovery. It was pointed out that the assumption is based on the system overperforming against the trajectories and it was confirmed that the forecast looks positive and the indicators are good. The Board was advised of the importance of focussing on H2 from a financial perspective as this is where some of the real risks lie. It was confirmed that the Trust will be meeting with NHSI to discuss this area of the plan.

It was reported that the 2021/22 Capital and Cash Plan has been revised to reflect the updated spend profile of schemes and completion of the hospital site; Community Cluster Building, new Neonatal Unit, medical equipment, digital investment, etc. It was reported that the Capital Expenditure for 2021/22 is £26.3m, with a year-end cash balance FCT of £47.6m.

The Board was advised that the Resource and Business Development Committee was provided with an update on the H1 Finance Plan on the 24.6.21.

Month 1 Financial Position

- Month 1 = £1.3m deficit, £0.9m behind plan. This did not have any of the ERF included in this figure.
- Cash in the bank is £92.7m and Capital spend is £2m.
- Drivers for variance:
  - Surgery £0.7m - Pay £0.6m, historic overspend plus additional related to restoration and recovery.
  - Research £0.1m – increase costs of CORE/infrastructure and commercial income lower than plan.
- M2 will provide a more accurate depiction of where the Trust is at.

- Strategic risk management (*strategic risks/mitigation*):
  - Wellbeing and mental health of staff; organisational de-briefing, SALS.
  - RSV surge/Covid-19 surge; surge plans, some pivot towards emergency care.
  - Health inequalities; CYP transformation, enhancing preventative programmes.
  - Financial exposure and risk; H1 only, non-recurrent investments.
  - Maintain safe care with rapid recovery and staff pressures; Patient Safety Strategy, People recovery.

The Chair drew attention to the difficult targets that have been set for the Trust in 2021/22 but pointed out that they do fit with the organisation's strategic direction. A lot of work has taken place to prepare for this and it feels like huge progress has been made in terms of safety and quality. The Chair advised that the Board recognises that the Trust is heading in the right direction but is also aware of the challenges, especially those relating to finance.

Fiona Beveridge felt that the plan was very stretching and queried the Trust's approach to keeping staff motivated and positive about the plan. It was reported that discussions

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are taking place in terms of a comms plan/crafting of narrative. A formal comms plan will be compiled ensuring clarity and encompassing staff in the next phase of the organisation's journey. Weekly briefings will also continue, and the Divisions will discuss the plan during team meetings. It was confirmed that a paper will be submitted to the Exec Team and Trust Board in due course in respect to this area of work. Louise Shepherd pointed out that there is further work to do around research, innovation and education and advised that these areas will be progressed once the new Director of Research and Innovation, John Chester, commences in post.

The Chair thanked all those involved in providing an update on the various elements of the 2021/22 Annual Plan.

Resolved:
The Trust noted the contents of the 2021/22 Annual Plan.

21/22/34 Serious Incident Report

The Serious Incident report was submitted to the Trust Board to provide a performance position for open and closed incident investigations that met the serious incident criteria and were reported externally to the Strategic Executive Information System (StEIS). The following points were highlighted:

- It was reported that there were zero Never Events in April 2021.
- There are five ongoing incidents currently under investigation which are on target to meet the date of completion that was agreed with the CCG and the families of the respective patients.
- A review of twenty-six incidents took place of which it was found that contributory factors showed that the primary theme identified was communication, both verbal and written. Documentation issues were also a recurring theme which linked to communication factors. A further two linked contributory factors to both communication and documentation were human factors and escalation issues. The outcome of the review will be built into the Trust's Safety Strategy going forward.

Resolved:
The Board received and noted the contents of the Serious Incident report for April 2021.

21/22/35 Use of the Mental Health Act

The Board received an update of activity in relation to the Mental Health Act (1983) for the reporting period from the 1.9.20 to the 31.3.21. The following points were highlighted:

- It was reported that during the reporting period four children or young people were admitted to a paediatric ward at Alder Hey who had Deprivation of Liberty Safeguard (DoLS) orders in place. All four DoLS were in place for their residences prior to admission.
- In addition, 11 urgent DoLS applications were made for young adults lacking mental health capacity and three standard DoLS applications were made for long-term now adult patients who lacked capacity.
- In January and February 2021, training regarding the Mental Health Act was provided by Hill Dickinson via Teams to senior staff within the Trust and on call managers, a total of 77 staff members received this training.
- The Board was advised that as a result of the CQC Section 31 notice to the Trust, it has been agreed that level 1 mental health awareness training will be provided to Doctors, Nurses, AHPs and HCAs on a three yearly basis. This is

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currently in development as an e-learning resource and is aimed to be implemented in September 2021.

Resolved:
The Board received and noted the report on the Use of the Mental Health Act (1983) for the half year.

21/22/36 Use of Restrictive Physical Intervention and Clinical Holding Annual Report 2020/21

The Board received the 2020/21 Annual Report for the Use of Restrictive Physical Intervention and Clinical Holding. For the reporting period from the 1.4.20 to the 31.3.21, the Trust reported 175 incidents regarding the use of restrictive physical interventions or clinical holding of children and young people accessing services at Alder Hey. The Board was advised that there has been an increase in the number of incidents reported in 2019/20 which is attributable to the work undertaken in 2020 to support appropriate recording. Attention was drawn to the table that is included in the report that shows incidents involving restrictive physical interventions or clinical holding reported across the Trust per Division.

There were no serious harm incidents reported regarding the use of restrictive physical intervention and clinical holding in relation to children, young people or staff during this reporting period. There was a total of 25 incidents relating to harm of which 4 related to patients, 19 to staff members and 4 to others which tends to relate to the carer of the patient or family member who is present with the patient.

It was reported that CALM training commenced in December 2020. Training is complete for staff on the Tier 4 Children's Inpatient Unit and a 'Train the Trainer' approach is being adopted across the Trust to ensure staff continue to receive accredited training on a regular basis. The Board was advised that CALM is a training provider that is part of the 'BILD Association of Certified Training' and have demonstrated that their training services comply with the Restraint Reduction Network Training Standards, the NHS England Standard Contract and CQC regulations.

Fiona Marston queried the follow up process for staff to see how they feel after this type of incident and whether it has had an impact on them. The Board was advised that following the completion of an incident form relating to constraint or clinical holding a debrief should be conducted with the respective member of staff and support offered. It was pointed out that these type of incidents are not just confined to children and young people who have mental health/behavioural issues and the training that is taking place is to support staff around restraints and clinical holding, help staff acknowledge when a child is becoming stressed and anxious in order to de-escalate a situation and avoid injury and harm. It was pointed out that there are various types of restraint, for example, hand holding, and this information will be included in reports going forward.

The Chair felt that it would be beneficial at some point for the organisation to be able to benchmark itself against other providers. It was reported that data will be incorporated in the 2021/22 Annual Report to provide an overview of how the Trust compares nationally and with similar providers.

Resolved:
The Board received and noted the contents of the Use of Restrictive Physical Intervention and Clinical Holding Annual Report 2020/21

21/22/37 Mortality Report Q3/Q4

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The Board received the Mortality Report for quarter 3 and 4. The following points were highlighted:

- It was reported that there have been no potentially avoidable deaths in the cases that have been reviewed during this quarter and there are no issues of concern.
- The Trust has agreed to conduct a deep dive into the adult deaths at Alder Hey during the pandemic with the support of a physician from Aintree Hospital who has familiarity with reviewing adult mortality cases. It was pointed out that the Trust is giving this process as much rigour as possible and therefore will take slightly longer to report on the outcome.
- *Primary Diagnostics Categories* - The leading category is congenital disorders at 29% followed by cardiac conditions (20%) and then surgical. This is expected as a considerable part of Alder Hey's workload involves children with congenital abnormalities who require medical and often surgical input.
- *External Benchmarking* – Alder Hey had 59 deaths during the year against 52.8 expected deaths. The figures this year have been impacted by the Covid pandemic due to the Trust prioritising workload around the sickest patients, undertaking the high-risk cases and having much lower admissions than usual, all of which factors skewed the data. Birmingham Children's Hospital is the closest comparison to Alder Hey being a cardiothoracic centre and their figures show a greater increase in deaths.

The Chair thanked Nicki Murdock for the progress that has been made with this area of work and was glad to see that the Trust is linking in with hospices.

Resolved:
The Board received and noted the contents of the Mortality Report for Q3 and Q4.

21/22/38 PICU Organ Donation Activity - Annual Report 2020/21

The PICU Organ Donation Activity Annual Report for 2020/21 was submitted to the Trust Board for information and assurance purposes. The following points were highlighted:

- Alder Hey has had three organ donors out of a potential four resulting in eleven transplants.
- There were no missed potential organ donors. However, it is possible that the fourth potential donation might have been more successful if initially approached by the lead nurse/lead nurse of the donor.
- The Organ Donation Committee has been reformed and meets regularly. The Executive sponsor for organ donation activity is Dr. Adrian Hughes.

Resolved:
The Board received and noted the content of the PICU Organ Donation Activity Annual Report for 2020/21.

21/22/39 Cumulative Corporate Report – Top Line Indicators

The Division of Medicine, Community/Mental Health and Surgery provided an update on the following domains; Safe, Caring and Responsive as detailed in the Corporate Report.

The Chair asked the respective directors to pass the Board's thanks onto the Divisional teams for the hard work that is taking place and the progress that is being made.

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Quality and Safety

- Nathan Askew, thanked the Divisions for the work that has taken place in terms of the improved quality of responses to complaints.
- It was reported that the weekly patient safety meeting continues to provide Trust wide assurance that all incidents have Divisional and Corporate oversight and are managed appropriately.
- There have been 150 guidelines reviewed and approved over the last 6 weeks.

Resolved:
The Board received and noted the Divisional updates that are highlighted in the Corporate Report and the weekly cumulative Corporate Report top line metrics.

21/22/40 Cumulative Corporate Report – Top Line Indicators

People
Resolved:
The Board noted the people update that is highlighted in the Corporate Report and the weekly cumulative Corporate Report top line metrics.

21/22/41 Alder Hey People Plan

The Board received a strategic update on the Alder Hey People Plan and the organisation's response to the requirements of the national NHS People Promise.

Resolved:
The Board received and noted the contents of the Alder Hey People Plan.

Strategic Approach to Flexible Working

The approach for implementing a hybrid working model across the whole of the organisation was submitted to the Board. The Board was asked to support and endorse the adoption of a hybrid working model across Alder Hey.

It was pointed out that as a result of the pandemic, staff at Alder Hey have learnt to work in many different ways, including a significant shift to working from home for many. These new ways of working have been supported by a wholesale shift to Microsoft 365 which has enabled remote working to take place in a productive, effective and successful way. As the Trust emerges from lockdown and the pandemic one of the changes is that there is a clear support for a greater degree of flexible working. The Board was advised of the long-term goals and the work that is taking place to set out a framework for hybrid working. The Board was advised that this way of working will be a big enabler for the Trust in terms of space and estates. It was reported that feedback from staff following the briefing on 19.5.21 was really positive.

It was reported that a Hybrid Working Policy is in the process of being compiled along with guidance. The Board was advised of the next steps and attention was drawn to the Trust wide 'change management' programme that will be available to all teams who will be adopting a hybrid working model and the bespoke 'change management' programme that will be offered to those moving locations, including those moving to Liverpool Innovation Park, and any internal moves on the hospital site. It was confirmed that the Trust is working alongside WK Space in terms of the change management programme and the organisation is also liaising with the unions.

Fiona Beveridge drew attention to the concerns of organisations in terms of staff not performing well when working remotely and queried as to whether the Trust has thought

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about how it will manage performance in the event that staff don't meet their targets. The Board was advised that this area of work will be addressed over the next few months in terms of a Home working Policy and guidance for managers. There is also a lot of learning as a result of staff working from home over the last twelve months.

John Grinnell highlighted the complexities in terms of the changes to workspace, work model and location and felt that it is important to have an integrated programme and a co-ordinated approach in order to resolve any difficulties or potential risks that may occur and allay any fears that staff may have.

Resolved:
The Board confirmed their support for the adoption of a hybrid working model across Alder Hey

Disciplinary Policy

Resolved:
The Board approved the Trust's refreshed Disciplinary Policy and agreed for it to be published on the organisation's website by the end of June 2021.

BAME Inclusion Taskforce Update

The Board received an update on the ongoing work of the BAME Inclusion Taskforce. A number of slides were submitted and the following information was shared:

- Metrics and the monitoring of progress via WRES data and local data.
- New national targets.
- The Trust's ambition:
  - Remove process and barriers in Alder Hey that could sustain system racism.
  - Support opportunity for education and employment for under-represented groups.
  - Have a diverse and inclusive workforce which truly represents local population and will be a place where all staff feel their contribution as an individual is recognised and valued, and the care provided reflects this.
  - Define and create the cultural and behavioural changes that the organisation wants to see.
- Actions taken so far.

Fiona Marston provided the Board with an overview of the listening event that took place on the 24.5.21. It was reported that the session was styled as a follow up to the listening event and a number of different staff members attended. The WRES and local data was shared with the group and there were a number of queries raised by staff in terms of the aims of the metrics. The Chair asked that staff feedback any comments that they had to Claire Dove. The group also discussed the Terms of Reference for the BAME Inclusion Taskforce and the zero-tolerance policy poster that had been mocked up. A discussion also took place about recruitment and how the Trust wants to connect with local schools to improve BAME representation.

Louise Shepherd felt that the work that has taken place to date is brilliant but drew attention to the gap that the Trust has in respect to patients and families. The Board was advised that the Chief Nurse is very keen to do some work with nursing colleagues from a staff/patient perspective in terms of EDI.

The Chair thanked Melissa Swindell and Fiona Marston for sharing the presentation and providing an update.

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Resolved:
The Board noted the BAME Inclusion Taskforce update.

21/22/42 CYP MH As One (NHS X) Project Spotlight

A number of slides were presented to the Board to provide an overview of the children and young people 'As One' project. It was reported that the project received funding from NHS England to digitally innovate the CAMHS offering to patients in the Liverpool and Sefton region. Information on the following areas was shared:

- Case study for NHSE and aligns with NHSX new blueprint for CYPMH service delivery:
  - *Problem addressed:* CYP, families and professionals' feedback is that the mental health services help available is not clearly accessible, can feel confusing and even once in the system it is hard to navigate and get support whilst waiting.
  - *Solution delivered* – 'As One' mental health services integrated platform, bringing together a single point of access for referrals, support and resources for CYP and professionals (co-created with CYP and professionals, user design centred approach, platform building block for other specialities).
- Principles of user-centred design.
- Single referral form.
- Live demonstration of the platform.
- Ongoing and future work:
  - Referrals will directly integrate in to EPR systems.
  - Digitally book appointments.
  - Research – Independently evaluate the platform.
  - PROMS – Visual representation of the patient journey.
  - Community Paediatrics – Referral and PROMS to be added to the platform.
  - Utilise the platform as a springboard for further funding opportunities.

The Board was advised that partner agencies initially struggled to embrace this new way of working but are now very supportive. It allows children and young people to self-refer and the service is able to triage patients and track their journey. The new system has also made it easy for CYP to access the service.

The presenting team responded to a number of questions that related to the possibility of upscaling and showcasing this work and the plans in place for addressing inequalities in terms of CYP who don't have access to the internet or a device.

The Chair thanked the team for the presentation and commended the fabulous work that has taken place with children and young people in mind.

Resolved:
The Board noted the contents of the presentation received on the CYP MH 'As One' (NHSX) project.

21/22/43 Alder Hey in the Park Campus Development Update

The Board received an update on the progress, risks and actions on key capital projects. The following points were highlighted:

- *Schemes* – The construction of the Sunflower Building and Catkin building is progressing.

- *Neonatal Scheme* - The design for the new Neonatal Unit is ready for the tender to be issued on the 28.5.21.
- *Park Reinstatement* – The planned work to sow the grass seed is complete and beginning to flourish. It was reported that Phase 2 of the park reinstatement is in the process of being commenced. It was confirmed that Phase 1 of the park will open up at the end of June 2021.
- *Relocations* – The Trust has made a decision to lease space at Liverpool Innovation Park which will accommodate a number of corporate departments. The internal design of the space has been worked up over the last eight weeks, has been shared with staff and feedback has been taken on board. The design has now gone to the landlord for costing which is expected by the 28.5.21. This project will progress over the next few months.
- *North East Plot Development opportunities* – Work is continuing with the developer to progress potential service enhancements around the options for new family/patient accommodation at the top end of the site.
- Work is taking place to acquire a healthy living opportunity for the park. Capacity Lab and the Community Benefits Society have taken a number of ideas forward and Liverpool City Council are considering the proposal to socially prescribe the park using the Trust's teams.

The Chair informed the Board of the opportunity for a tour of the site/new buildings and advised members to contact Karen Critchley to arrange a date/time. It was queried as to whether there will be a garden party for staff when the park opens in June. The Board was advised that work is taking place with Capacity Lab to progress this.

Resolved:
The Board received and noted the contents of the Campus Development update.

21/22/44 Board Assurance Framework

The Board received a summary of the monthly updates to the BAF for review and discussion. The purpose of the report is to provide assurance on how strategic risks that threaten the achievement of the Trust's strategic plans and long-term objectives are being proactively managed, in accordance with the agreed risk appetite. The BAF for Alder Hey currently consists of a set of 12 principal risks aligned to the Trust's strategic objectives. The following points were highlighted:

- It was reported that the Trust has received a positive opinion from MIAA in terms of the organisation's assurance framework.
- BAF risk 1.2 is to be updated in respect to the risk relating to the pressures on the Trust's Emergency Department.
- It was felt that as a Board there is a necessity to review the impact of Covid on the organisation and what it means in reality for the Board.
- All BAF risks have been scrutinised by the respective Assurance Committees. This process will continue in 2021/22.

Resolved:
The Board received and noted the contents of the Board Assurance Framework report as at the end of April.

21/22/45 Board Assurance Committees

RABD – The approved minutes from the meeting that took place on the 26.4.21 were submitted to the Board for information and assurance purposes. During the meeting on the 24.5.21 there was a focus on the 2020/21 H1 Finance Plan.

SQAC – The approved minutes from the meeting that took place on the 21.4.21 were submitted to the Board for information and assurance purposes. During the meeting on the 19.5.21 the Committee received reports from the Complaints Plan and discussed the increase of attendances that ED is experiencing. The Governance Team provided a position statement in respect to NICE guidelines and the Committee received an update on the Detect Study.

PAWC – The approved minutes from the meeting that took place on the 23.3.21 were submitted to the Board for information and assurance purposes. During the meeting on the 18.5.21 there was a focus on the Recovery Plan and the importance of supporting staff in the Emergency Department. Reports were also submitted on mandatory training and DBS checks.

Resolved:
The Board noted the updates and approved minutes of the respective Assurance Committees.

21/22/46 Any Other Business

There was none to discuss.

21/22/47 Review of the Meeting

The Chair felt that the content of the 2021/22 Annual Plan and the presentations submitted during the meeting were clear and provided sufficient information to keep the Board updated on the business of the organisation.

The Chair challenged members to reflect as to the Board is consistently demonstrating the Trust's values. The overall consensus was that Board members try very hard to live the organisation's values and a couple of points were made in respect to having more visible togetherness with senior staff from external organisations/partners, and meeting on a face to face basis as a Board once it is safe to do so.

Date and Time of Next Meeting: Thursday the 24th June 2021 at 9:00am via Teams.

000022

Alder Hey Children's NHS Foundation Trust
Trust Board - Part 1
Action Log (April 2021-March 2022)

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Actions for the 27th May 2021							
25.2.21	20/21/252.1	Mortality Report, Q2	*National Changes to the Child Death Mortality Process* - Acquire written confirmation from David Levy's office acknowledging that the Trust's system is fully compliant and in line with the new national guidance.	Nicki Murdock	27.5.21	On Track	**19.3.21** - A verbal update will be provided on the 25.3.21. **25.3.21** - It was reported that the Trust is awaiting a reply from David Levy's office. **29.4.21** - It was reported that the Trust is awaiting a reply from David Levy's office. **20.5.21** - The Medical Examiner regional lead, Dr Huw Twamley, has discussed the Trust's Medical Examiner proposal with Julie Grice. He awaits national guidance with reference to the stand alone tertiary paediatric centres. The national Medical Examiner, Alan Fletcher, has also looked at this. There is no further guidance available yet, but Alder Hey's system is more rigorous than the national process. **ACTION TO REMAIN OPEN**
29.4.21	21/22/05.1	Covid-19 Recovery Plan 2021/22	*2021/22 H1 Planning* - Test the actions that are in place to ensure they are able to sustain progress going forward in respect to safe care and the wellbeing of staff.	Adam Bateman	27.5.21	Closed	**27.5.21** - This item has been included on the agenda. **ACTION CLOSED**
29.4.21	21/22/09.2	SALS Update	Look at the possibility of evaluating the SALS service/model and link in with the Psychology Department at the University of Liverpool to capture the outcome in a framework in terms of demonstrating the difference/impact that the service has made.	Melissa Swindell	27.5.21	On Track	18.6.21 - Update to be provided on the 24.6.21.
29.4.21	21/22/09.3	BAME Taskforce Update	Capture the RES data and metrics in a report to measure/track improvement and representation of the organisation's workforce.	Melissa Swindell	27.5.21	Closed	**27.5.21** - This item has been included on May's agenda. **ACTION CLOSED**
Actions for the 24th June 2021							
27.5.21	21/22/31.1	Covid-19 Recovery Plan 2021/22	*National Paediatric Accelerator* - Provide an update on the Paediatric Accelerator Bid Summary Position.	Adam Bateman	24.6.21	Closed	18.6.21 - This item has been included on June's agenda. **ACTION CLOSED**
Actions for the 28th July 2021							
27.5.21	21/22/31.2	Covid-19 Recovery Plan 2021/22	*Access and Restoration* - Submit an action plan for ED and RSV during July's Trust Board meeeting.	Adam Bateman	28.7.21	On Track	
Actions for the 30th September 2021							
25.2.21	20/21/252.2	Mortality Report, Q2	*Adult Covid Deaths* - Conduct a deep dive into the six Covid-19 adult deaths that took place at Alder Hey during the pandemic and submit a report to the Board on the overall outcome, in April/May 2021.	Nicki Murdock	30.9.21	On Track	

Status	
Overdue	(red)
On Track	(green)
Closed	(blue)

Draft

Audit & Risk Committee Annual Report 2020/21

The Audit and Risk Committee

The Audit Committee operated to its prior remit from April 2020 to August 2020. The Audit & Risk Committee was formed in September 2020 due to a committee re-set exercise following a lighter touch committee process in Spring and Summer due to the global pandemic. The Audit & Risk Committee now combines the former Audit Committee and the strategic risk elements of the Integrated Governance Committee.

The Audit & Risk Committee has primary responsibility for reviewing the effectiveness of the framework in place for the identification and management of risks and associated controls, corporate governance and assurance frameworks. In addition, the Committee provides a form of independent check upon the executive arm of the Board.

In addition, the Committee shall provide the Board of Directors with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Trust's activities both generally and in support of the Statement of Internal Control.

The conduct of this remit is achieved firstly, through the Committee being appropriately constituted, and secondly by the Committee being effective in ensuring internal accountability and the delivery of audit, risk, anti-fraud measures, management, governance and assurance services.

This report outlines how the Committee has complied with the duties delegated by the Board through its Terms of Reference, developments it has undertaken throughout the year, key assurances that it can provide to the Board and proposed developments for 2021/22.

Constitution

The membership of the Committee comprises three Non-Executive Directors. Its Chair has 'recent relevant financial experience'. The Director of Finance and Director of Corporate Affairs together with the Operational Director of Finance (until August 2020) are invited to attend the whole meeting, whilst the Associate Director of Nursing and Governance, Chief Operating Officer and Divisional Directors are invited to attend for the risk related items. The Committee may request the attendance of the Chief Executive and any other officer of the Trust to answer any points which may arise. In addition, the Internal and External Auditors and Anti-Fraud Specialist are invited to each meeting. A schedule of attendance at the meetings is provided in Appendix A which demonstrates full compliance with the quorum requirements and regular attendance by those invited by the Committee. The Audit & Risk Committee members also have the opportunity through the year to meet in private with Internal Audit and External Audit.

In spite of the global pandemic, five meetings were held as normal during the financial year 2020/21 of which one, in June was devoted to consideration of the External Auditors report on the Annual Accounts and ISA 260. The Committee has an annual Work Plan with meetings timed to consider and act on specific issues within that Plan.

A Summary Report is presented to the Board following each Audit & Risk Committee meeting highlighting the documents received at the meeting, key risks and positive areas discussed and any matters to escalate to the Board or other Committee. Final minutes are also submitted to Board once approved.

Work undertaken in 2020/21 in accordance with Terms of Reference

In discharging its duties, the Committee meets its responsibilities through requesting assurances from internal and external sources and from Trust Officers and by directing and receiving reports in that regard. The Committee also undertakes a self-assessment of its own performance and identifies any actions required. For

2020/21 the self-assessment was condensed to take account of pressures on committee members owing to the pandemic. The Committee Chair has therefore identified priority areas for further development in 2021/22, incorporating some actions carried forward from 2019/20 as a result of the pandemic.

The following paragraphs provide an overview of the work undertaken by the Audit & Risk Committee in each of the main areas of its responsibility.

Risk Management

In September 2020 the Audit & Risk Committee assumed responsibility for the strategic elements of risk previously overseen by the Integrated Governance Committee – primarily review of the Board Assurance Framework, Corporate Risk Register and risk management policies and procedures. Detailed review of operational risks was transferred to the newly created Care Delivery Board; an executive committee with attendance from the Divisional Directors, The Care Delivery Board also reviews strategic level risk before reporting to the Audit & Risk Committee.

To discharge its responsibilities the Committee receives the following key reports to each of its meetings (since September 2020):

- Board Assurance Framework with updates on each of the risks from the Executive with overarching narrative provided by the Director of Corporate Affairs. Whilst the Committee reviews the Board Assurance Framework in respect of compliance with the risk management framework, management of each of the individual risks are overseen in detail by either the Board or one of the other assurance committees. The Committee refers any areas of query or concern to those committees for investigation.
- A report from the Care Delivery Board outlining the current key risk themes, actions taken and any barriers to their mitigation. This report also includes the current Corporate Risk Register, highlighting new risks, risks with changed risk scores, those that are longstanding and actions taken.
- An analysis of the Trust Risk Register (risks <15 score) highlighting the number and percentage of risks overdue review, those without an action plan or with actions overdue and providing an analysis of risks by severity and division / corporate service.

The Committee also received a risk management presentation from the Assistant Director of Nursing & Governance describing how risk is managed throughout the Trust and a Fraud Risk Matrix in line with the requirements of the NHS Counter Fraud Authority.

During 2019/20, the organisation was compliant with the NHS CFA Standard 1.4 relating to Fraud Risk Management.

External Audit

External Audit services continued to be provided by Ernst & Young in 2020/21.

At its June meeting, the Committee received the ISA260 “Audit Results Report” and provided signed a Letter of Representations in relation to the 2019/20 financial statements as required by the auditors.

An unqualified opinion on the accounts for 2019/20 was provided to the Board on 22nd June 2020.

In September 2020 the External Auditors presented a report which provided analysis and trends from their use of data analytics in their audit process. This provided some areas for management interest and understanding.

The auditors also regularly provide a “Health Audit Committee” briefing which updates the Committee on developments in finance and governance relevant to the health sector.

Internal Audit

The Internal Audit service is provided by Mersey Internal Audit Agency (MIAA). The Head of Internal Audit Opinion and Annual Report for 2019/20 reported that MIAA have complied with NHS mandatory Internal Audit Standards and those of the Chartered Institute for Internal Auditors.

Internal Audit provides an independent and objective opinion to the Accountable Officer, the Board and the Audit & Risk Committee on the degree to which risk management, control and governance are effective. From time to time, and as directed by the Audit & Risk Committee they also provide an independent and objective advisory service to help management improve the organisation’s risk management, control and governance arrangements.

The Audit & Risk Committee approved MIAA's Internal Audit Plan for 2020/21. The Plan is structured to enable the Head of Internal Audit to provide an annual opinion which gives an assessment of the:

- effectiveness of the internal control system, risk management and governance. This is based on the output of a range of risk-based audits contained within the Internal Audit Plan. The opinion takes account of the relative risk of these areas and management's progress in addressing identified control weaknesses.
- design and operation of the underpinning Assurance Framework and supporting processes.

MIAA provide a summary of the audit recommendations issued and management's response to address them to each meeting of the Audit & Risk Committee. For any reports that are assessed as "Limited" or "No" Assurance a senior representative from the audit area is invited to the meeting to present their detailed action plan to address the findings. There were no internal audit reports with a limited opinion in 2020/21.

The Internal Auditors also undertake a quarterly exercise to assess the implementation of agreed recommendations that have passed their implementation deadline and a "Follow Up" Report is provided to the Committee. The Committee then reviews outstanding actions until completion. During the year the Committee Chair was focussed on gaining assurance around follow up actions to encourage the timely closure of any potential gaps in the control environment and has worked with MIAA and Management to identify improvements in the process. In 2020/21 significant progress was made in implementing agreed actions, including the small number remaining from prior years. Due a significant delay in implementation of agreed recommendations management were requested to present to the January meeting an update on the outstanding recommendations from the 2017/18 Consultant Job Planning audit.

The following reports were received from Internal Audit during 2020/21.

- 2020/21 Internal Audit Plan and Progress Reports on its delivery.
- Internal Audit Charter.
- Internal Audit Reports for the following areas:
  - Data Security & Protection Toolkit.
  - Safeguarding.
  - Project Management.
  - PFI Compliance.
  - Assurance Framework Opinion.
  - Follow Up of Agreed Recommendations.
  - Conflicts of Interest.
  - Covid 19 Expenditure.
  - Non Clinical Claims.
  - Financial Systems Key Controls.
  - Clinical Audit.
- Head of Internal Audit Opinion and Annual Report for the year ending 31 March 2020.

During the course of the year the Committee considers any changes in the environment or risk within the organisation which may require changes to the agreed Internal Audit Plan. These may be highlighted by the Internal Auditors, Management or the Committee. In 2020/21, the following changes were agreed:

- The Workforce Planning audit was replaced with an audit of Covid 19 expenditure.
- The Risk Management audit was deferred to 2021/22 with additional elements of risk management added to the Internal Auditor's review of the Assurance Framework to ensure a basic level of review of risk management was undertaken.

In 2019/20 the Trust commissioned KPMG to undertake an advisory project looking at the governance of the innovation companies managed under the ACORN partnership. Since the creation of the Innovation Committee, detailed oversight of the implementation of the actions arising has transferred to that Committee and the Audit & Risk Committee continues to receive summary updates on progress to enable oversight of their completion.

The Committee wishes to highlight to Board that, despite the significant impact of the pandemic on the Trust's operations, the Internal Auditors were able to deliver the majority of their planned work which enabled the provision of their annual opinion. The Committee recognised this significant achievement and passed on its thanks to both management and MIAA in this regard.

The key conclusion from MIAA's work for 2020/21 as provided in the Head of Internal Audit Opinion and Annual Report was that 'Substantial Assurance' was given that there were generally sound systems of internal control to meet the organisation's objectives and that controls are generally being applied consistently.

Anti-Fraud Services
As with the Internal Audit Service, the Anti-Fraud Service is provided by MIAA. The service provided is grouped into four areas - Inform and Involve, Hold to Account, Prevent & Deter and Strategic Governance. The work undertaken is a mixture of proactive such as fraud awareness communications, provision of MIAA and NHS Counter Fraud Authority alerts and bulletins and reactive such as reviews of potential frauds, fraud exercises such as National Fraud Initiative data matching and procurement fraud prevention.

The planned work is submitted to the Audit & Risk Committee for approval in the Anti-Fraud Annual Workplan. Throughout the year regular updates on the work undertaken to prevent and detect fraud, including any investigations and an Annual Report of the delivery of the Workplan is also provided.

The following reports were received from the Anti-Fraud Service during 2020/21:

- Anti-Fraud Work Plan 2020/21 and Progress Reports on delivery of the Plan.
- Anti-Fraud Annual Report for the year ending 31 March 2020 including Self-Assessment against the NHSCFA "Standards for Providers" self-review tool.

Other Assurance Sources
The Committee reviewed the 2019/20 Annual Reports of the assurance committees of the Trust prepared to support of approval of the Annual Governance Statement.

Finance

The following reports were provided by the Finance Team in relation to the annual report and accounts process and to provide assurance on financial control matters:

- 2019/20 Annual Report and Accounts.
- Losses and Special Payments.
- Waiver of Financial Regulations.
- Treasury Management Policy (for approval).

Governance

During the year a number of documents were reviewed by the Audit & Risk Committee in relation to its own governance and the governance processes within the Trust:

<u>Audit Committee Governance:</u>

- Audit & Risk Committee Work Plan.
- Terms of Reference for the Audit & Risk Committee.
- 2019/20 Audit Committee Annual Report.
- Review of the IGC Self-Assessment Actions with relevant actions added to the Audit Committee Self-Assessment Actions to produce combined Audit & Risk Committee Self-Assessment Actions, with remaining actions transferred to the Care Delivery Board to implement.

<u>Trust Governance</u>

- 2019/20 Annual Reports of the Trust's assurance committees.
- 2019/20 Quality Account.
- Draft 2019/20 Annual Governance Statement.
- Gifts & Hospitality Register.
- Update on the CQC Actions relevant to Audit & Risk Committee's remit.
- Update on the Brilliant Basics Project.

It is usual for the Audit & Risk Committee to receive the Trust's Quality Account at the June meeting. Due to the impact of the pandemic, NHSI/E relaxed some of its year-end requirements including the incorporation of the Quality Report into the Annual Report for 2020/21. Nor was it required to be subject to a limited assurance audit by EY. It was therefore not felt appropriate for ARC to receive the Quality Report, which received scrutiny from the Safety and Quality Committee solely.

Developments in 2020/21

During the year the Committee:

- Introduced the remit of the Audit & Risk Committee and established its relationship with the Care Delivery Board.
- Received expanded analysis of the Corporate Risk Register enabling greater challenge and support of this key document.
- Introduced analysis of the Trust Risk Register enabling it to form a view on the effectiveness of risk management at all levels of the organisation and within particular divisions / services.
- Introduced divisional attendance to the risk elements of the agenda.
- Received the first Fraud Risk Matrix.
- Agreed the introduction of a Fraud Risk Champion.
- Introduced the "Policy for Engagement of External Auditors in Non-Audit Work".
- Agreed the importance of a Going Concern Report and the additional assurance available from an annual report on the effectiveness of project management from the Delivery Management Office and reporting (to be determined) from the Data Quality Team with these reports to be introduced in 2021/22.
- Invited the Chair of RABD to attend its' June 2020 meeting where the 2019/20 Annual Report and Accounts were presented, to enable additional review and challenge of the document before its recommendation to Board.
- Reviewed the KPIs for Internal Audit.
- Agreed a Client Satisfaction Questionnaire to be issued following completion of each internal audit.
- Agreed a KPI for the timeliness of provision of responses to draft internal audit reports by management

Assurance Statement

Based on the Committee's processes for gaining assurance as summarised above, the Committee members can confirm that:

- **they agree to the declaration reported to the Board of Directors in respect of the Annual Governance Statement.**
- **the Assurance Framework is fit for purpose.**
- **systems for risk management identify and allow for the management of risk.**
- **there are robust governance arrangements.**
- **there are sound systems of financial control.**
- **the Trust operates a robust internal control environment.**

Whilst providing these assurances the Audit & Risk Committee has clearly expressed its expectations in relation to areas where controls need to be strengthened and these will be addressed in the coming year.

Committee Developments and Priorities for 2021/22

Whilst the Committee has performed its duties as delegated by the Board and mandated through governance requirements, in the forthcoming year focus will be given to the following matters to further improve its effectiveness:

Actions carried forward from 2020/21:

1. Sources of assurance in addition to Internal and External Audit and Anti-Fraud will be considered such as from the Delivery Management Office on the governance and delivery of projects, from the Associate Director of Nursing and Governance on the effectiveness of the risk management process and from any third parties who provide assurance to the Trust (such as NHS Shared Business Services) and, where appropriate reporting to the Committee will be introduced (to be undertaken at April 2021 meeting).
2. Whilst it was agreed in 2020/21 that formal reporting to the Audit & Risk Committee from the Clinical Audit Team and CQAC (now SQAC) would be introduced this has not yet occurred due to the pausing of much of Clinical Audit's activities in 2020/21 due to the pandemic. The Chief Nurse is undertaking a review of Clinical Audit in Q1 2021/22 to which the Audit & Risk Committee Chair will provide input.
3. A discussion about other information which might be useful to the Audit & Risk Committee in understanding / improving internal control will be undertaken. (This might include information relating to quality, performance targets and financial control and data relating to key quality dimensions) (to be undertaken at April 2021 meeting).
4. A process is to be introduced to evaluate the effectiveness of External Audit.

New developments for 2021/22:

5. Following the first six months operation of both Audit & Risk Committee and the Care Delivery Board a review will undertake of their effectiveness and to ensure that the split of responsibilities between the two groups is appropriate.
6. The Trust's risk appetite is currently being further developed following approval by Board of the high level narrative risk appetite statements in March 2021. Following anticipated development of risk appetite scores the Committee will oversee their implementation into the risk management process and reporting.

Kerry Byrne, Audit and Risk Committee Chair
April 2021

AUDIT AND RISK COMMITTEE – RECORD OF ATTENDANCE 2020/21

The quorum necessary for the transaction of business: two members

Member/Date of Meeting	2020			2021		TOTAL	
	Apr	June	Sept	Nov	Jan		
	Audit Committee			Audit & Risk Committee			
MEMBERS							
Mrs Kerry Byrne (Non-Executive Director)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	5 / 5	100%
Mrs Anita Marsland (Non-Executive Director)	✓	✓	✓	N/a	N/a	3 / 3	100%
Dr Fiona Marston (Non-Executive Director)	N/A	N/A	X	✓	✓	2 / 3	67%
Ian Quinlan (Non-Executive Director)	N/A	✓	N/A	N/A	N/A	1/1	-
Quoracy achieved	YES	YES	YES	YES	YES	5 / 5	100%
ATTENDEES							
Mr John Grinnell (Director of Finance/Deputy CEO)	✓	✓	X	✓	✓	4 / 5	80%
Mrs C Liddy (Director of Operational Finance and Innovation)	✓	✓	N/A	N/A	N/A	2 / 2	100%
Mrs R Lea (Deputy Director of Finance)	x	✓	✓	x	x	2 / 5	40%
Ms Erica Saunders (Director o0f Corporate Affairs)	✓	✓	✓	✓	✓	5 / 5	100%
Mrs Louise Shepherd (Chief Executive)	✓	N/A	N/A	N/A	N/A	1 / 1	-
Mr A Bateman (Chief Operating Officer)	N/A	N/A	✓	✓	✓	3 / 3	100%
Alfie Bass (Divisional Director – Surgery)	N/A	N/A	X	Rep.	x	1 / 3	33%
Lisa Cooper (Divisional Director – Community)	N/A	N/A	Rep.	x	Rep.	2 / 3	67%
Urmi Das (Divisional Director - Medicine)	N/A	N/A	✓	✓	✓	3 / 3	100%
Mrs C Umbers (Associate Director of Nursing & Governance)	N/A	N/A	✓	✓	✓	3 / 3	100%
Ernst & Young (External Audit)	HR	HR/ RT	HR	HR	HR	5 / 5	100%
MIAA (Internal Audit)	GB / KS	KS	GB / KS	GB / KS	GB / KS	5 / 5	100%
Anti-Fraud Service	MM	N/A	VM	x	VM	3 / 4	75%

Ernst & Young Representatives:
Mr R Tyler (RT); Mr H Rohimun (HR)

Mersey Internal Audit Agency Representatives:
G Baines (GB); Mrs K Stott (KT)

Anti-Fraud Service:
Ms V Martin (VM); Michelle Moss (MM)

Draft

Safety and Quality Assurance Committee Annual Report 2020/21

The Safety and Quality Assurance Committee

Formerly the Clinical Quality Assurance Committee, the Safety and Quality Assurance Committee was formed in September 2020 following the pause of the majority of board sub-committees during the summer due to the global pandemic which, in turn, triggered a committee reset exercise to ensure a safe restart of governance structures. As its name suggests, the Committee's purpose is to provide assurance to the Board of Directors that the Trust's systems, processes and culture ensure the highest standards of clinical quality in terms of patient safety, clinical effectiveness and patient/carer experience to our children and young people and their families.

The Committee has delegated authority from the Trust Board to oversee the effectiveness of clinical quality, clinical practice and clinical governance within the Trust, ensuring that all supporting systems and processes enable staff to adhere to their duty of candour. It does this principally via the Divisions and Clinical Directors who have the authority to implement the Trust's Quality Strategy and supporting Quality Aims within and across divisions, supported by the central functions.

Constitution

The Membership comprises:

- Non-Executive Director x 3 one of whom shall be the Chair
- Medical Director
- Chief Nurse
- Director of Nursing
- Director of Finance/Deputy CEO
- Chief Operating Officer
- Director of Corporate Affairs
- Director of Human Resources and Organisational Development
- Director of Strategy & Partnerships
- Chief Digital Information Officer
- Divisional Directors
- Divisional Clinical Leads for Safety x3

Expected to attend each meeting: Deputy Medical Director, Deputy Director of Nursing, Associate Director for Nursing and Governance and the Director of Infection Prevention and Control. To ensure that SQAC remains strategic and assurance led, it is also supported by the Clinical Quality Steering Group (CQSG) which monitors quality assurance at an operational level and reports in to SQAC.

How the Committee managed its governance processes during the pandemic

- Terms of Reference were comprehensively reviewed during the summer to ensure a focussed oversight role of key issues relating to the safety of our patients and their families.
- Particular scrutiny was placed on the restoration and recovery of elective surgery and safe management of patients who were directly impacted as a consequence of the Covid-19 pandemic.
- Following the February 2020 inspection by the Care Quality Commission which resulted in an overall rating of ‘Good’ with ‘Outstanding’ in the Caring domain, the Committee closely scrutinised and monitored all actions within its remit. This has been been completed and sign off is being sought.
- Top 3 priorities were agreed to drive the agenda ensuring a strategic focus on quality and safety:
    1. Medication safety
    2. Deteriorating patients
    3. Parity of esteem for children and young people
- The Committee requested regular updates and assurances regarding the changes to the reporting system for waiting list management with monthly reports received from the Safe Waiting List Management Oversight Group.
- The Committee has received briefings with regard to the partnership with KPMG to deliver the Operational Excellence Programme, including the Brilliant Basics project incorporating the new Quality Hub and related workstreams
- The Committee monitored key risks and assurance that strategic plans and operational policies exist to mitigate all significant risks pertaining to delivery of safe and high quality services through the Board Assurance Framework.
- The Committee continued to approve policies as appropriate/required.
- In response to the global pandemic, enhanced assurances were provided to the Committee regarding enhanced infection, prevention and control measures with exception reports received at each meeting.
- The Committee closely monitored progress against the Section 31 Notice actions and received assurances in this regard until full removal of the conditions. A programme board to oversee the long term approach to caring for CYP with complex challenging behaviours has been established and will report to the Committee during the coming year.
- The Committee regularly monitored the agreed quality metrics in the Trust Corporate Report and received substantive reports with regard to specific issues identified.
- The Committee was kept well-informed of governance arrangements regarding the acceptance of adult Covid-19 patents.
- The Committee received the Trust Quality Account for 2019/20.
- The Committee retained its oversight of the Trust’s clinical audit function during the year, receiving reports on progress against the annual plan and improvement actions in terms of completion rate.
- Quarterly Complaints Reports continued to be received throughout the year.
- The Committee continued to receive detailed oversight quality improvement reports including:
    1. Sepsis / detect programme updates
    2. ICON Programme
    3. Positive Behavioural Support Update
    4. Intensive Support Team – Update on Pilot

Assurance Statement

Based on the information provided, the Committee members can confirm that the assurance framework is fit for purpose and that the control environment is operating at a satisfactory level with areas to improve on highlighted below. SQAC also agrees to the declaration reported to the Board in respect of the Annual Governance Statement; the AGS is scrutinised by the Audit and Risk Committee, whose chair is also a member of SQAC.

Committee Priorities for 2021/22

- The Committee will continue to focus on its top 3 priorities, adopting appropriate measures and metrics.
- The Committee will continue to monitor the Trust's Covid response regarding restoration of services.
- The Committee will continue to hold the Divisions to account for quality performance and will seek to drive measurable improvements in key quality indicators from 'ward to board'.
- The Committee will focus on improvement in relation to the Trust complaints process and performance against associated indicators.
- The Committee will maintain an overview of the Quality Ward Round process to provide an in depth understanding of the issues facing each service and department.
- The Committee will oversee the delivery and governance of the Brilliant Basics programme as part of the Operational Excellence work with KPMG, in the context of the Trust's overall strategic direction and re-stated ambition to achieve an overall 'Outstanding' rating from CQC.
- The Committee will consider recommendations for the adoption and renewal of policies relating to safety and quality.
- The governance arrangements that underpin the Change Programme and its specific projects will again be a key focus for the Committee in the coming year, but with greater emphasis upon benefits realisation.

Prof Fiona Beveridge
Committee Chair
May 2021

APPENDIX A

SAFETY & QUALITY ASSURANCE COMMITTEE - RECORD OF ATTENDANCE 2020/21

Quorum: A quorum shall consist of the Chair or nominated deputy, one other NED, two Executive Directors (one of whom must be the Medical Director or Nursing Director or Chief Nurse, or their designated deputy).

Member/Date of Meeting	2020									2021			TOTAL	
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
MEMBERS														
Anita Marsland (Non-Executive Director)	MEETINGS SUSPEND	MEETINGS SUSPEND	MEETINGS SUSPEND	✓ (Chair)	NO MEETING HELD	✓ (Chair)	✓ (Chair)	N/A	N/A	N/A	N/A	N/A	3/3	100%
Fiona Beveridge (Non-Executive Director)				N/A		X	✓	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	6/7	86%
Kerry Byrne (Non-Executive Director)				N/A		✓	X	✓	✓	✓	✓	✓	6/7	86%
Fiona Marston (Non-Executive Director)				✓		N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1	100%
Shalni Arora (Non-Executive Director)				X		N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1	0%
Nathan Askew (Chief Nurse)				N/A		N/A	N/A	✓	✓	✓	✓	✓	5/5	100%
Nicki Murdock (Medical Director)				Rep		✓	✓	✓	✓	✓	X	✓	7/8	88%
Pauline Brown (Acting Chief Nurse)				✓		✓	X	N/A	N/A	N/A	N/A	N/A	2/3	67%

Pauline Brown (Director of Nursing)	ED DUE TO COVID PANDEMI	ED DUE TO COVID PANDEMI	ED DUE TO COVID PANDEMI	N/A	NO MEETING HELD	N/A	N/A	✓	✓	✓	✓	X	4/5	80%
Phil OConnor (Acting Director of Nursing)				X		X	✓	N/A	N/A	N/A	N/A	N/A	1/3	33%
John Grinnell (Director of Finance)				✓		✓	X	✓	X	✓	✓	✓	6/8	75%
Adam Bateman (Chief Operating Officer)				✓		✓	X	✓	✓	✓	X	✓	6/8	75%
Erica Saunders (Director of Corporate Affairs)				✓		✓	✓	✓	✓	✓	X	✓	7/8	88%
Melissa Swindell (Director of HR & OD)				✓		✓	✓	✓	X	X	✓	✓	6/8	75%
Dani Jones (Director of Strategy & Partnerships)				✓		✓	Rep.	Rep.	✓	✓	✓	✓	6/8	75%
Lachlan Stark (Head of Planning & Performance)				X		N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1	0%
Denise Boyle (Assoc. Chief Nurse, Surgery)														
Cathy Wardell (Assoc. Chief Nurse, Medicine)				X		N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1	0%
Jacqui Pointon				✓		N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1	100%

(Assoc. Chief Nurse, Community)	C	C	C											
Rose Douglas (Assoc. Chief Nurse, Community)				X		N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1	0%
Kate Warriner (Chief Digital Information Officer)				Rep.		Rep.	Rep.	Rep.	Rep.	Rep.	Rep.	Rep.	0/8	0%
Alfie Bass (Divisional Director, Surgery)				Rep.		Rep.	Rep.	Rep.	Rep.	Rep.	X	X	0/8	0%
Urmi Das (Divisional Director, Medicine)				N/A		✓	✓	✓	✓	✓	X	✓	6/7	86%
Adrian Hughes (Divisional Director, Medicine)				✓		N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1	100%
Lisa Cooper (Divisional Director, Community)				✓		✓	✓	✓	✓	✓	✓	✓	8/8	100%
Divisional Clinical Leads for Safety x3				N/A		CT / JP	CT / JP	CT	CT	CT/JP	JP	CT	7/8	88%
Quoracy achieved				YES		YES	YES	YES	YES	YES	YES	YES	11/11	100%

Member/Date of Meeting	2019									2020			TOTAL	
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
ATTENDEES														
Adrian Hughes (Deputy Medical Director)				N/A		✓	✓	✓	✓	✓	✓	✓	7/7	100%
Cathy Umbers (Associate Director for Nursing and Governance)							✓	✓	X	✓	X	✓	4/8	50%
Phil OConnor (Deputy Director of Nursing)				N/A		N/A	N/A	✓	✓	X	✓	✓	4/5	80%
Beatrice Larru (Director of Infection Prevention Control)				N/A		✓	✓	✓	X	✓	✓	✓	6/7	86%

Draft

Resources and Business Development Committee Annual Report 2020/21

The Resources and Business Development Committee

The Resources and Business Development Committee was established by the Board of Directors to be responsible for overseeing financial, operational and contractual performance, workforce metrics, business development and strategic IM&T issues and the approval of business cases to limits delegated by the Board.

The principal delegation of the Board's responsibilities are as follows:

- Review and recommend business, operational and financial plans to the Board
- Monitor performance, assuring the Board that performance is being managed in line with plans
- Ensure value for money is obtained by the Trust
- Identify related areas of strategic and business risk and report these to the Board
- Oversee the development of the Trust's long-term financial strategy, its Business Development Strategy and its Investment Strategy

The conduct of this remit was achieved firstly through the Committee being appropriately constituted and secondly by the Committee being effective in ensuring internal accountability and the delivery of assurance on specific issues.

This report outlines how the Committee has complied with the duties delegated by the Board through its terms of reference and identifies key actions to address developments in the Committee's role.

Constitution

In accordance with the terms of reference which are reviewed annually the membership of the Committee comprises:

- Non-Executive Directors x 3 [one of whom shall be the Chair]
- Director of Finance
- Director of Operational Finance and Innovation
- Chief Operating Officer
- Director of Human Resources
- Chief Digital and Information Officer
- Director of Strategy & Partnerships

Expected to attend each meeting is: Director of Corporate Affairs, Associate Director of Finance, Director of Marketing and Communications and Development Director.

The Committee may request the attendance of any Non-Executive Directors, any Executive Directors and any other persons by invitation. A schedule of attendance at the meetings is provided in Appendix A which demonstrated that all meetings in-year were quorate. The

Committee has an annual work plan with meetings timed to consider and act on specific issues within that plan.

A Summary Report is presented to the Board following each RABD Committee meeting highlighting the documents received at the meeting, key risks and positive areas discussed and any matters to escalate to the Board or other Committee. Final minutes are also submitted to Board once approved.

How the Committee managed its governance processes during the pandemic

RABD was one of the only committees that continued to meet monthly throughout the relaxation of governance arrangements during the global pandemic.

The following areas were the main focus of the Committee's attention:

- The Committee received regular updates on the new Financial Framework implemented as a result of the Covid-19 pandemic and highlighted these to the Board as appropriate.
- Oversight of the Trust's overall financial position and main risks in relation to cash and the potential impact any in-year, and future operating deficits may have on the capital plan.
- The Committee continued to maintain oversight of the Alder Hey in the Park Campus works including any emerging financial risks as a direct consequence of the pandemic and lock down periods.
- Regular review of the Board Assurance Framework and adjustments to this as required.
- Maintained an oversight on all major investments and business developments including the Neonatal Business Case and updates regarding changes since the original business case was approved in 2018.
- Safe Waiting List Management programme
- PPE manufacturing proposals and existing stock updates
- Future productivity and benefit opportunities in terms of service delivery during the pandemic and maintaining the safety of our patients.
- the Committee was kept abreast of the significant investment and change in digital across Alder Hey during 2020/21
- Review of progress against the organisations top 5 risks/priority areas for 2020/21:
    - Productivity – specifically restoration activity targets / performance following the step-down of elective activity
    - Benefit Realisation
    - Cash
    - CAPEX
    - Building Projects
- Continued to approve policies as required
- Oversight of the marketing strategy, including brand management, market positioning, marketing activity, market research and competitor analysis.
- Approval of Trust write-offs
- 2021/22 financial planning
- Scrutinised the Trust's 5 Year Capital Plan prior to submission to the Board of Directors.
- The financial outcome for the year end with a risk rating of 3.
- NHS Oversight Framework

Assurance Statement

Through the various mechanisms set out above, the Committee has gained assurance that the Trust's financial, operational and contractual systems and processes were operating at a satisfactory level, with year-end performance ending positively.

The Committee holds key relationships with CQAC and WOD enabling:

- Links to specific issues in a multi-factorial way; specifically in relation to financial considerations and quality improvements;
- Risks to service quality are addressed; and
- Strong links with workforce risks and financial performance.

Committee Priorities for 2021/22

Whilst the Committee has performed its duties as delegated by the Board it has identified a number of areas to focus on during 2021/22:

- Once agreed, the Committee will continue to focus and seek assurances regarding the top five risks/key priority areas in 2021/22 which would enable the Trust to deliver its clinical, operational and financial targets.
- Ensure the activities and areas of focus by the Committee remain focussed on the effects of moving into the new hospital.
- Enhance the monitoring and reporting of follow-up actions taken in respect of its areas of responsibility.
- The governance arrangements that underpin the Change Programme and its specific projects will again be a key focus for the Committee in the coming year.
- The Committee will continue to hold the Divisions to account for their performance and will seek to drive measurable improvements in efficiency and productivity.
- Ensure that particular attention is given to the CIP and Business Development initiatives in 2021/22 and beyond, in the context of the national financial environment
- Ensure a committed focus on the COVID-19 Financial Strategy and in particular the risks as a consequence of the pandemic.

Ian Quinlan
Committee Chair
May 2021

RESOURCES AND BUSINESS DEVELOPMENT COMMITTEE - RECORD OF ATTENDANCE 2020/21

The quorum necessary for the transaction of business: Chair or nominated deputy, one other NED, one Executive Director

Member/Date of Meeting	2020									2021			TOTAL	
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
MEMBERS														
Mr Ian Quinlan (Non-Executive Director)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	12/12	100%
Mrs Claire Dove (Non-Executive Director)	X	✓	✓	✓	✓	X	X	✓	✓	✓	✓	✓	9/12	75%
Kerry Byrne (Non-Executive Director)	✓	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1	100%
Dame Jo Williams (Non-Executive Director)	✓	✓	X	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	2/3	67%
Shalni Arora (Non-Executive Director)	N/A	N/A	N/A	N/A	N/A	✓	✓	✓	X	X	✓	✓	5/7	71%
Mr John Grinnell (Director of Finance)	✓	✓	✓	X	✓	✓	✓	✓	✓	✓	✓	✓	11/12	92%
Mrs Claire Liddy (Director of Operational Finance)	✓	✓	✓	✓	X	N/A	N/A	N/A	N/A	N/A	N/A	N/A	4/5	80%
Mr Adam Bateman (Chief Operating Officer)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	12/12	100%
Mrs Melissa Swindell (Director of HR & OD)	✓	X	✓	✓	X	✓	✓	✓	✓	✓	✓	✓	10/12	83%
Ms Kate Warriner (Chief Information Officer)	X	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/12	83%
Mrs Dani Jones (Director of Strategy & Partnerships)	✓	✓	✓	X	✓	✓	✓	✓	✓	✓	✓	✓	11/12	92%
Quorum achieved	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	12/12	100%

ATTENDEES														
Ms Erica Saunders (Director of Corporate Affairs)	✓	✓	✓	✓	✓	✓	✓	X	✓	✓	X	✓	**10/12**	**83%**
Mrs Rachel Lea (Associate Finance Director)	✓	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	✓	**11/12**	**92%**
Mr. Ken Jones (Associate Director of Financial Control and Assurance)	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	✓	✓	✓	✓	**4/4**	**100%**
Mr Mark Flannagan **(**Director of Marketing and Coms)	X	✓	✓	✓	✓	✓	✓	✓	✓	X	X	X	**8/12**	**67%**
Mr David Powell (Development Director) / **Mrs Sue Brown** (Associate Development Director)	✓ ✓	✓ x	✓ ✓	X ✓	X ✓	X X	X X	X ✓	X X	X X	X ✓	X X	**3/12** **6/12**	**25%** **50%**
Mrs Claire Liddy (Director of Innovation)	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	✓	✓	✓	✓	✓	✓	✓	**7/7**	**100%**

Draft

People and Wellbeing Committee Annual Report 2020/21

The People and Wellbeing Committee

Formerly the Workforce and Organisational Development Committee, the People and Wellbeing Committee (PAWC) was formed in September 2020 following the pause of the majority of board sub-committees due to the global pandemic which, in turn, triggered a committee reset exercise to ensure the safe restart of Trust governance structures.

The Committee is responsible for providing strategic direction and board assurance in relation to all workforce matters, and making recommendations, as appropriate, on workforce matters to the Board of Directors, in support of the delivery of high-quality patient and family centred care. In particular ensuring that the five strategic objectives relating to **The best people doing their best work** as set out in the Trust's People Plan are met:

- Compassionate and learning culture
- Leadership development and talent management
- Wellbeing
- Future workforce
- Equality, diversity and inclusion
- Alder Hey Academy

This report outlines how the Committee has complied with the duties delegated by the Board through its terms of reference and identifies key actions to address developments in the Committee's role.

Constitution

In accordance with the terms of reference, the membership comprises:

- 1 Non-Executive Director [Chair]
- 2 Non-Executive Directors
- Director of Human Resources & Organisational Development
- Chief Operating Officer
- Chief Nurse
- Medical Director
- Director of Corporate Affairs
- Director of Marketing & Communications
- 1 x Senior representative from each Division

The following are expected to attend each meeting: Deputy Director of Human Resources,

Associate Director of OD, Equality and Diversity Lead and the Chair of Staff Side.

How the Committee managed its governance processes during the pandemic

In discharging its duties, the Committee met its responsibilities through self assessment and review, requesting assurances from Trust officers and directing and receiving reports from relevant individuals.

The following areas were the main focus of the Committee's attention:

- The Committee agreed its top 5 priorities as
    1. Staff availability
    2. Staff wellbeing
    3. Workforce planning
    4. Flexible working
    5. Quality of education
- Staff Survey 2020 – updates
- Scrutiny of progress against the targets and measures contained within the People Plan 2019-2024
- CQC Action Plan updates against regulatory requirements monitored at PAWC
- Ratification of all relevant workforce policies
- Leadership Development and Talent Management updates
- Focus on working from home and measures taken to make sure that people are safe and supported at home
- Approval of the EDS2 Annual Report 2019/20 and monitoring against the Workforce Race Equality & Workforce Disability Equality standards with a particular lens on the effects of Covid on BAME staff
- Additional focus has been applied to health and safety during the pandemic to ensure monitoring of compliance against strategic H&S requirements and achievement of our statutory requirements
- Monitoring of workforce metrics within the Corporate Report including:
    - Sickness absence - particularly in light of the Covid-19 pandemic
    - PDR compliance
    - Medical appraisals
- Monitoring of key workforce risks and assurance that strategic plans and operational policies exist to mitigate all significant risks through the Board Assurance Framework
- Updates regarding the HEE NW Annual Assessment Visits 2015-2019
- The Committee received the minutes from the following working groups
    - LNC
    - JCNC
    - Education Governance
    - Health & Safety
    - EDI Task Force - including specific updates listed on the agenda
- The Committee received an updated on the implementation of the mandated e-roster system
- Development and implementation of a Staff Advice & Liaison Service (SALS)
- Approval of cost of living increase for non-AFC staff
- The committee was kept abreast of internal communications with a particular focus on how the Trust was maintaining contact with those working from home

DRAFT

Assurance Statement

Through the various mechanisms set out above, the Committee has gained assurance that the delivery of the Trust People Strategy was on track and all key workforce risks were being managed. It has clearly expressed its expectations in relation to areas where controls need to be strengthened and these will be addressed in the coming year.

The committee Chair is a member of the Resources and Business Development Committee ensuring strong links with workforce risks and financial performance.

Monthly key issues reports were presented to the Board with final minutes submitted once approved. The key issues reports highlighted:

- agenda items discussed/approved,
- key risks/matters of concern to for escalation, and
- positive highlights of note and issues for other committees

Committee Priorities for 2021/22

Whilst the Committee has performed its duties as delegated by the Board it has identified a number of areas to focus on during 2020/21:

- Focus on monitoring the implementation of the refreshed People Plan
- Focus on monitoring the implementation of the Change Programme
- Focus on the key areas which would enable the Trust to deliver its people related targets, namely:
    - Health & Wellbeing
    - Leadership Development & Talent Management
    - Equality, Diversity and Inclusion
    - Future Workforce Development
    - The Academy

- Enhance the monitoring and reporting of follow-up actions taken in respect of its areas of responsibility.

Claire Dove
Committee Chair
May 2021

PEOPLE & WELLBEING COMMITTEE – RECORD OF ATTENDANCE 2020/21

The quorum necessary for the transaction of business will consist of the Chair or nominated deputy, one other NED and the Director of Human Resources and Organisational Development.

	April 2020	June 2020	Sept 2020	Nov 2020	Jan 2021	March 2021	TOTAL	
MEMBERS								
Mrs C Dove (Non-Executive Director)	NO MEETING DUE TO COVID PANDEMIC	NO MEETING DUE TO COVID PANDEMIC	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair	4 / 4	100%
Mr I Quinlan (Non-Executive Director)			✓	X	✓	✓	3 / 4	75%
Prof. F Beveridge (Non-Executive Director)			X	✓	X	✓	2 / 4	50%
Mrs M Swindell (Director of HR&OD)			✓	✓	✓	✓	4 / 4	100%
Mr A Bateman (Chief Operating Officer)			✓	✓	X	✓	3 / 4	75%
Mrs P Brown (Acting Chief Nurse)			✓	✓	N/A	✓	3 / 2	100%
Mr N Askew (Chief Nurse)			N/A	X	✓	X	/ 4	50%
Prof. N Murdock (Medical Director)			X	Deputy	X	Deputy	2 / 4	50%
Mr M Flannagan (Director of Marketing & Communications)			✓	✓	✓	X	3 / 4	75%
Ms E Saunders (Director of Corporate Affairs)			✓	✓	✓	X	3 / 4	75%
1 x Senior representative from Surgical Division			X	X	X	X	0 / 4	0%
1 x Senior representative from Medical Division			X	RC	CW	X	2 / 4	50%
1 x Senior representative from Community Division			RG	RG	X	LM	3 /4	75%
Quorum achieved?			YES	YES	YES	YES	4/4	100%

	April 2020	June 2020	Sept 2020	Nov 2020	Jan 2021	March 2021	TOTAL	
ATTENDEES								
Sharon Owen (Deputy Director of HR)	NO MEETING	NO MEETING	✓	✓	✓	✓	4 / 4	100%
Jo Potier (Associate Director of OD)			✓	✓	X	✓	3 / 4	75%
XXXX (Equality & Diversity Lead)			Post vacant				-	-
Tony Johnson (Staff Side Chair)			✓	✓	X	X	2 / 4	50%

Draft

Innovation Committee Annual Report 2020/21

The Innovation Committee

The Innovation Committee was established by the Board of Directors to assist in overseeing and monitoring execution of the Trust's strategic direction in relation to innovation.

The Committee will operate under the broad aims of developing the Trust's Innovation Strategy and related activities, to provide assurance to the Board that delivery in this area supports the Trust's Strategic Plan.

The Committee has the authority on behalf of the Board to:

- Steer the development of a cohesive approach to innovation, ensuring that the Trust maximises the opportunities presented by its facilities, clinical expertise, partnerships and networks;
- Make recommendations to the Board to pursue specific projects and initiatives that fall within the duties set out below;
- Seek and commission external advice as deemed appropriate to the successful delivery of this agenda.

The conduct of this remit was achieved firstly through the Committee being appropriately constituted and secondly by the Committee being effective in ensuring internal accountability and the delivery of assurance on specific issues.

This report outlines how the Committee has complied with the duties delegated by the Board through its terms of reference and identifies key actions to address developments in the Committee's role.

Constitution

In accordance with the terms of reference which are reviewed annually the membership of the Committee comprises:

- 3 Non-Executive Directors (one of whom is the Chair)
- Chief Executive
- Medical Director
- Clinical Director of Innovation
- Director of Finance
- Managing Director of Innovation
- Director of Corporate Affairs
- Chief Digital and Information Officer

Expected to attend each meeting are the Deputy Managing Director of Innovation, Finance Lead for Innovation and Director of Research.

The Committee may request the attendance of any Non-Executive Directors, any Executive Directors and any other persons by invitation. The Committee continued to meet on a bi-monthly basis during the pandemic given its oversight of the innovation projects directly related to Covid-19. A schedule of attendance at the meetings is provided in Appendix A which demonstrates each meeting was quorate. The Committee has an annual work plan with meetings timed to consider and act on specific issues within that plan.

A Summary Report is presented to the Board following each Innovation Committee meeting highlighting the documents received at the meeting, key risks and positive areas discussed and any matters to escalate to the Board or other Committee. Final minutes are also submitted to Board once approved.

How the Committee managed its governance processes during the pandemic

In discharging its duties the Committee met its responsibilities through self assessment and review, requesting assurances from Trust officers and directing and receiving reports from relevant individuals.
A decision was made to repurpose the Innovation Team in order to focus on Covid-19.

The following areas were the main focus of the Committee's attention:

- Oversight of the development and acceleration of the Trust's Innovation Strategy
- Projects were paused other than those that were supporting the crisis covering the following three areas of work in respect of Covid-19 problem solving:
  - innovative sourcing/ rapid proto-typing,
  - rapid digital improvement and
  - commercial opportunities.
- The Committee was kept abreast of the significant digital developments relating to patient safety specifically:
  - The Distancer
  - ICL Visor
  - Hygenie Project
  - Telemedicine virtual visiting (screen2screen)
  - Implementation of virtual assistants
- Updates on the collaborative model for innovation across the Liverpool City Region
- Ensuring that key risks to innovation are identified and monitored by the Committee via the Board Assurance Framework and underpinned by detailed assurance reports as appropriate.
- The Committee received updates on active commercial agreements and the due diligence carried out by the organisation in respect to these agreements
- Monitoring of outputs from the review of assurance arrangements under the ACORN partnership undertaken by KPMG.

Assurance Statement

Through the various mechanisms set out above, the Committee has gained assurance that the Trust's innovation function is operating effectively and in line with relevant standards and legislation.

Committee Priorities for 2021/22

Whilst the Committee has performed its duties as delegated by the Board it has identified a number of areas to focus on during 2021/22:

- Positioning the organisation to continue in its COVID-19 response in line with the Trust's response strategy
- Continued portfolio performance review and streamlining to identify viable projects
- Continued input into the collaborative model for innovation across the Liverpool City Region
- Providing assurance to the Board that key risks are identified and monitored, and continuous review of key risks
- Financial planning and resource development

Shalni Arora
Committee Chair
May 2021

INNOVATION COMMITTEE - RECORD OF ATTENDANCE 2020/21

The quorum necessary for the transaction of business:
Chair or nominated deputy, one other NED and two Executive Directors.

Member/Date of Meeting	2020/21					TOTAL	
	May	July	Oct	Dec	Feb		
MEMBERS							
Mrs Shalni Arora (Non-Executive Director)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	5/5	100%
Dr Fiona Marston (Non-Executive Director)	✓	✓	✓	✓	✓	5/5	100%
Mr Ian Quinlan (Non-Executive Director)	N/A	N/A	✓	X	✓	2/3	67%
Mrs Louise Shepherd (Chief Executive)	X	✓	✓	✓	✓	4/5	80%
Dr Nicki Murdock (Medical Director)	✓	X	✓	X	X	2/5	40%
Mr Iain Hennessey (Clinical Director of Innovation)	✓	✓	✓	✓	✓	5/5	100%
Mrs Claire Liddy (Managing Director of Innovation)	✓	✓	✓	✓	✓	5/5	100%
Mr John Grinnell (Director of Finance)	✓	✓	✓	X	✓	4/5	80%
Ms Erica Saunders (Director of Corporate Affairs)	✓	✓	✓	X	✓	4/5	80%
Ms Kate Warriner (Chief Digital and Information Officer)	✓	✓	✓	✓	X	4/5	80%
Quorum achieved	YES	YES	YES	YES	YES	5/5	100%

ATTENDEES							
	May	July	Oct	Dec	Feb	TOTAL	
Emma Hughes (Deputy Managing Director of Innovation)	N/A	N/A	N/A	N/A	✓	1/1	100%
Emma Hughes (Assoc. Chief Innovation Officer)	✓	✓	✓	✓	N/A	4/4	100%
Rachel Lea (Finance Lead for Innovation)	X	X	✓	✓	X	2/5	40%
(Director of Research)	✓	X	✓	X	✓	3/5	60%

BOARD OF DIRECTORS

Thursday 24th June 2021

Paper Title:	Board Self Certification 2021 - Compliance with NHS Provider Licence conditions
Report of:	Director of Corporate Affairs
Paper Prepared by:	Director of Corporate Affairs Deputy Director of Finance

Purpose of Paper:	Decision ■ Assurance ■ Information ☐ Regulation ■
Background Papers and/or supporting information:	NHS Foundation Trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence, have the required resources available if providing commissioner requested services, and have complied with governance requirements.
Action/Decision Required:	To note ☐ To approve ■
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ■ **The best people** doing their best work ■ Sustainability through **external partnerships** ■ Game-changing **research and innovation** ■ **Strong Foundations**
Resource Impact:	None identified

NHS Improvement Provider Licence Self-Assessment - Update as at June 2021

Licence Condition	Current position	Assurance	Gap	Action
Section 1 – General Conditions				
G1 - Provision of information	All monitoring submissions provided by deadline via the portal. Additional documents provided on request.	• Deputy DoF checks financial returns before submission and reports to RBD • Annual Report and Accounts audited and scrutinised by Audit Committee then BoD	None identified at present	None – the Trust remains compliant with this condition.
G2 – Publication of information	Trust reports placed in the public domain in accordance with NHSI requirements, e.g. Annual Report and Accounts	• Hard copies of reports available at AMM and within Trust premises; summary sent to members • Trust website • Trust Publication Scheme	None identified at present	NHSI bulletins and guidance for any new requirements
G3 – Payment of fees to Monitor	This condition reflects the power given to NHSI/Monitor under the Act to require licensees to pay fees in relation to its regulatory functions. Fees are not currently in place, not has any decision yet been taken as to whether NHSI will begin to charge fees.	N/A	N/A	None required at present. Provision has never been implemented

Licence Condition	Current position	Assurance	Gap	Action
G4 - Fit and proper persons as Governors and Directors	Trust arrangements have been updated to reflect CQC regulation 5 (applies to directors only). This includes a separate declaration, amendments to Directors' contracts/letters of appointment, additional checks around insolvency and disqualification and revised Recruitment Policy	• Annual declaration process • Directors undergo enhanced DBS checks and other robust pre-employment checks • Existing directors undertake DBS refresh • Annual checks for insolvency and disqualification • Governors subject to DBS checks	None at present	None outstanding – CQC satisfied with current arrangements following last inspection
G5 – Monitor guidance	Guidance consistently and stringently followed	• Reports to Board Committees e.g. Annual Plan, Annual Report and Accounts, Corporate Report (NHS Oversight Framework) • Well Led follow-up review completed. • FTSU self-review tool received by Trust Board	None identified at present	Continue to track new guidance through appropriate committee on publication
G6 – Systems for compliance with licence conditions and related obligations (i.e. NHS Acts and Constitution)	Systems and processes are currently set up to ensure compliance with provisions of the Licence and other mandatory requirements; risk set out in BAF. Constitution reflects current legislationt.	• Corporate Report links to NHS Oversight Framework • Certification produced in accordance with paras 10 and 11 of this Condition annually covering financial year. • Monthly Board and assurance committee oversight of BAF	None identified at present	Compliance with Licence conditions formally reviewed by the Board as part of its annual work plan.

Licence Condition	Current position	Assurance	Gap	Action
G7 – Registration with the Care Quality Commission	Currently registered without conditions for all relevant services.	All inspection and registration issues reported monthly through appropriate assurance committee/s and Board	None identified at present – s31 conditions lifted within nine weeks	Continue with regular engagement meetings with CQC; ensure NHSI informed of all key issues.
G8 – Patient eligibility and selection criteria	This condition requires licensees to set and publish transparent patient eligibility criteria and to apply these in a transparent manner. Explicit eligibility criteria are not currently published for individual AH services, however they are covered in a range of activities: • Declarations of compliance with specialist service specifications; • Information on individual services provided on trust website; • Clinical discussions at MDT level including where any ambiguity exists for example with regard to age limits (16 – 18) and where adult transition services are not established	• At MDT level • Compliance with service specifications issued by Spec Comm. • Quality contract monitoring by CCG	Individual eligibility and selection criteria not currently published together in one place due to nature of services – all children under 16 eligible depending on clinical need.	Statement equality of service access within Annual Report for 2020/21
G9 – Application of S.5 (Continuity of Services)	All previous Mandatory Services migrated to Commissioner Requested Services as of 1st April 2013. Three services derogated as part of Spec Comm assessment of trusts	NHSE (Spec Comm) contract monitoring meetings	Derogation in place for the following services: Paediatric Congenital Heart Disease – Level 1 Service Paediatric High	SDIP to be put in place for each service with plan to achieve compliance

Licence Condition	Current position	Assurance	Gap	Action
	against service specifications		Dependency Care, Paediatric Medicine Gastroenterology, Hepatology and Nutrition Cancer services for teenager and young adults All Age Congenital Heart Disease Network Haematopoietic Stem Cell Transplantation (Children)	
Section 2 – Pricing				
P1 – Recording of Information	Under this condition NHSI may require licensees to record information on their costs in line with guidance. They may also require licensees to record other information, e.g. quality and outcome data to support NHSI in carrying out its pricing functions. PLICS has been developed and is actively used by Divisions routinely and as part of GIRFT and specialty reviews; and the finance team have developed a suite of reports in support of service line reporting.	• Reports to RBD and Audit Committee • Trust submits National Cost Collection data to NHS England & Improvement in line with timetable and guidance • NHS Improvement rated Alder Hey's costing information, methodologies and governance as significantly above average of all trusts in England in 2020 • Suite of quarterly reports to Divisions regarding service line, consultant, procedure and patient level cost and income	None identified at present	Continue to develop and refine reporting / costing at service line level / patient level costing.

Licence Condition	Current position	Assurance	Gap	Action
		performance.		
P2 – Provision of information	As G1 above. NHSI places particular emphasis on the availability of consistently recorded and accurate information on costs to enable them to set prices for NHS services at an appropriate level.	Reports to RBD and Audit Committee. The Trust has been assessed for its costing processes against NHSE&I's assessment framework and has scored 93% which is the fourth highest in the country.	None identified at present	As above P1
P3 – Assurance report on submissions to Monitor	Links to P2 above – NHSI will require assurance on the accuracy of the costing information provided.	Reports to RBD and Audit Committee as required	N/A	N/A
P4 – Compliance with the National Tariff	This condition imposes an obligation on providers as well as commissioners to charge for NHS services in line with National Tariff.	Reports to RBD and Audit Committee as required. Contracts signed with commissioners based on national standard contracts. Impact of national tariffs reflected in financial plans agreed by the Board.	None currently identified	None in terms of compliance with the Licence condition, however the impact of the 2021/22 financial framework (H1 and H2) on the Trust will need to be closely monitored and discussed with NHSI/E as appropriate.
P5 – Constructive engagement concerning local tariff modifications	The Act gives NHSI responsibility for setting the process and rules around local pricing modifications. This condition requires licensees to engage constructively with commissioners to try to reach	Reports to RBD	None currently identified	Trust will follow guidance as and when applicable and where local pricing modifications are agreed with Commissioners which meet NHSI's criteria for notification.

Licence Condition	Current position	Assurance	Gap	Action
	local agreement before applying to NHSI for a local modification. Deputy Director of Finance works closely with local commissioners to address specific service issues.			
Section 3 – Choice and Competition				
C1 – The right of patients to make choices	This condition requires licensees to notify their patients when they have a choice of provider either under the NHS Constitution or conferred locally by commissioners. It requires providers to tell patients where they can find information about the choices they have in a way that is not misleading. Any information provided to AH patients would be on the basis of clinical need. No inducements are offered to referring clinicians by the Trust under any circumstances. Patients are informed of their NHS Constitution right to choosing alternative providers for those waiting longer than 18 weeks from RTT.	Reports to RBD re contract performance.	None currently identified	Patient information leaflets updated as required to include aspects on choice where appropriate
C2 – Competition oversight	This condition prohibits the licensee from entering into or maintaining agreements that have the object or effect of	This will be considered on a case by case basis when the Trust bids for or establishes contractual arrangements for	None currently identified	None currently identified

Licence Condition	Current position	Assurance	Gap	Action
	preventing, restricting or distorting competition to the extent that it is against the interests of health care users.	the provision of services. Trust follows relevant guidance where applicable. Major contract changes reviewed and approved by the Board and or R&BD.		
Section 4 – Integrated care				
IC1 – Provision of integrated care	The Trust remains active in pursuing plans to deliver better integration of children's services in the city with Liverpool CCG and other partners. Significant partnership work has continued in-year, detailed in the Trust's Annual Report.	Reports to BoD	None currently identified	None from a compliance perspective
Section 5 – Continuity of Services				
CoS1 – Continuing provision of Commissioner Requested Services	All services currently delivered as per contract/agreed specification issued by commissioners	Quality meetings with commissioners. Reports by exception to Board Contract performance review meetings with Commissioners	See G9 above	See G9 above
CoS2 – Restriction on the disposal of assets	Trust has an up to date asset register	Register maintained by the Finance team	None currently identified	None currently identified
CoS3 – Standards of corporate governance and financial management	Trust has robust corporate and financial governance arrangements that are compliant with all relevant guidance including that issued by NHSI	Internal and external audit reports provided to Audit Committee, Board and Governors. Annual Governance Statement, HoIAO, CQC well-led	None currently identified	Track any updates and changes to guidance

Licence Condition	Current position	Assurance	Gap	Action
		inspection and monthly monitoring of financial and performance risks. The Board commissioned an independent follow-up review against the Well Led Framework against NHSIs Guidance which states that '*It is evident that the Trust has both maintained, and significantly developed, the well-led governance infrastructure since the last CQC review with many aspects of outstanding practice demonstrated across all KLOE domains….As part of the commitment to Alder Hey's vision of 'a healthier future for children and young people', there has been a clear drive to improve ward to board governance to further embed excellence.*'		
CoS4 – Undertaking from the ultimate controller	NHSI/Monitor defines the 'ultimate controller' as being anybody that could instruct the licensee to carry out particular actions, i.e. the parent company of a subsidiary that has been licensed by Monitor. If there is no single body that could instruct the licensee in this way, the licensee does not have an ultimate controller and there is	N/A	N/A	N/A

Licence Condition	Current position	Assurance	Gap	Action
	no need for an undertaking under this condition. Monitor has clarified that governors and directors of FTs are not regarded as ultimate controllers and will not need to provide undertakings.			
CoS5 – Risk pool levy	In the event of a provider entering special administration, the costs of administration will be met by a central fund known as the risk pool. This condition requires the licensee to contribute to the funding of the pool if NHSI/Monitor requests it.	N/A	N/A	N/A
CoS6 – Co-operation in the event of financial distress	This condition applies when a licensee fails to meet the test of sound financial management (as per CoS3) under the RAF, in which case the licensee is required to provide information to 3rd parties as directed by NHSI and allow access to premises. We are currently rated as 2 under the SOF.	Corporate Report scrutinised by RBD and BoD Ops Board and Exec Performance Reviews oversee operational delivery.	None identified	Trust financial position and risks to delivery continues to be subject to regular review and update
CoS7 – Availability of resources	This condition sets out the Board certification requirement which aims to provide NHSI with reassurance that the Board has given consideration to the resources to be dedicated to the	All previous updates to certification requirements have been fulfilled either by the entire Board or by RBD as part of its delegated authority.	None identified	Certificate to be drafted for consideration by the Board to the required timescale and to be available for NHSI audit purposes.

Licence Condition	Current position	Assurance	Gap	Action
	provision of CRS over the coming 12 month period.			
Section 6 – NHS Foundation Trust Conditions				
FT1 – Information to update the register of NHS foundation trusts	Trust constitution, annual report, annual accounts and auditor's report have been consistently provided to NHSI/Monitor within the specified timescales.	Reports to the Board. Publication of Trust information on NHSI's website	None identified	Ensure any changes to guidance are tracked e.g. amended requirements in the ARM
FT2 – Payment to Monitor in respect of registration and related costs	This condition creates the provision for Monitor to charge fees specifically to FTs for the cost of regulation e.g. maintaining registers etc. No decision has yet been taken by NHSI/Monitor as to whether this will be put into practice however a separate consultation is planned. NB Monitor has had the power to levy fees from FTs since 2004 but has chosen not to do so.	N/A	N/A	N/A
FT3 – Provision of information to advisory panel	Monitor has set up its 'Panel for Advising Governors' as described by the 2012 Act. The panel has been created as a source of independent advice to governors in order to help them fulfil their role; the focus is on governors using the panel when	Governors are provided with all Board papers and full information about the Trust via briefings and at regular meetings. Key issues presented to Governors at every meeting Governors are regularly	None currently identified	Ensure any new Governors are aware of the process for submitting a query to the Panel as part of induction

Licence Condition	Current position	Assurance	Gap	Action
	their trust has failed in its obligations either under the constitution or the Act. Licensees are required to provide information to the panel when requested. NB. The Act requires a majority of governors to support the submission of a query following consideration at a full meeting of the Council of Governors.	reminded that they are able to observe Board and Committee meetings		
FT4 – NHS foundation trust governance arrangements	This condition builds upon the existing requirements set out in the Code of Governance and other guidance documents including the ARM. The Trust has consistently complied with the requirements to demonstrate the effectiveness of its governance arrangements.	External and internal audit reports to Audit Committee. There is a well-developed committee structure which is the subject of an annual effectiveness review.	None identified at present	Continue to ensure requirements are adhered to.

Erica Saunders
June 2021

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Condition FT4

Alder Hey Children's NHS Foundation Trust *Insert name of organisation*

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Corporate Governance Statement - in accordance with Foundation Trust condition 4 (Foundations Trusts and NHS trusts)
Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Foundation Trusts only)

These self-certifications are set out in this template.

How to use this template
1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

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Worksheet "FT4 declaration"

Financial Year to which self-certification relates: 2020/21 — Please Respond

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	[including where the Board is able to respond 'Confirmed']	#REF!
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	[including where the Board is able to respond 'Confirmed']	#REF!
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	[including where the Board is able to respond 'Confirmed']	#REF!
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	[including where the Board is able to respond 'Confirmed']	#REF!
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	[including where the Board is able to respond 'Confirmed']	#REF!
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	[including where the Board is able to respond 'Confirmed']	#REF!

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature J. Williams **Signature** L C Shepherd

Name Dame Jo Williams **Name** Louise Shepherd

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A — Please Respond

Worksheet "Training of governors"

Financial Year to which self-certification relates: 2020/21 Please Respond

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed	OK

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature	[signature]	**Signature**	[signature]
Name	Dame Jo Williams	**Name**	Louise Shepherd
Capacity	Chair	**Capacity**	Chief Executive
Date	24 June 2021	**Date**	24 June 2021

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Conditions G6 and CoS7

Alder Hey Children's NHS Foundation Trust	*Insert name of organisation*

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Systems or compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence
Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence (Foundation Trusts designated CRS providers only)

These self-certifications are set out in this template.

How to use this template
1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates: **2020/21**

Please complete the explanatory information in cell E36

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed	OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	Confirmed	Please fill details in cell E22

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.	

OR

3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.	

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

The actions taken by the NHS to respond to the COVID-19 pandemic included the suspension of the operational planning process for 20/21 and therefore financial plans were not concluded and an interim financial framework has been put in place that continues to provide funding on a block basis. The Trust Board have reviewed the cash balances and resources available and conclude there is adequate resources within the Trust. The Board have also considered the financial governance framework that operates within the Trust and its flexibility and preparedness to respond to financial challenge. For these reasons, the Board clearly see itself as a going concern basis in preparing the accounts

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature	[signature]	**Signature**	[signature]
Name	Dame Jo Williams	**Name**	Louise Shepherd
Capacity	Chair	**Capacity**	Chief Executive
Date	24 June 2021	**Date**	24 June 2021

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 24th June 2021

Paper Title:	**Access and recovery of services for children & young people**
Report of:	**Adam Bateman** **Chief Operating Officer**
Paper Prepared by:	Lachlan Stark, Associate Chief Operating Officer Planning & Compliance

Purpose of Paper:	Decision ☐ Assurance ■ Information ■ Regulation ☐
Background Papers and/or supporting information:	
Action/Decision Required:	To note ■ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ■ **The best people** doing their best work ☐ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Impact:	

1. Introduction

We have delivered substantial progress in the recovery of service for children and young people; we have provided more consultations and treatments to children and young people in May 2021 than we did in May 2019, before the Covid-19 pandemic.

The NHS is experiencing a surge in urgent care demand and there are acute demand pressures on the Emergency Department at Alder Hey.

We have mobilised preparedness for a respiratory syncytial virus (RSV) epidemic, with a potential surge in cases modelled from August 2021.

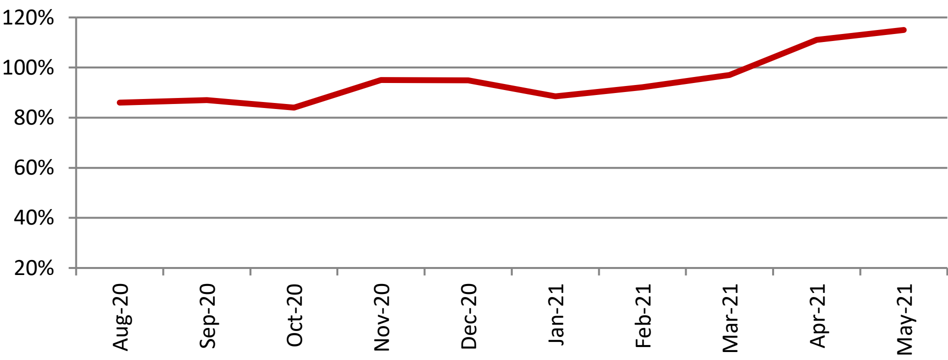
The confluence of high levels of elective activity against an outlook of rising demand for unplanned care and a possible RSV epidemic requires an organisation-wide capacity and workforce plan for September to March 2022. This is being prepared and the integrated plan will be shared with Trust Board in July 2021.

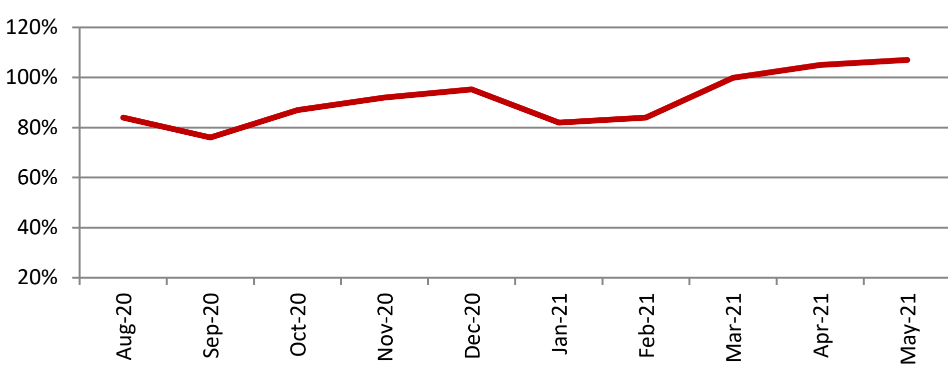
2. Recovery of planned care

2.1 Recovery against 2019 levels

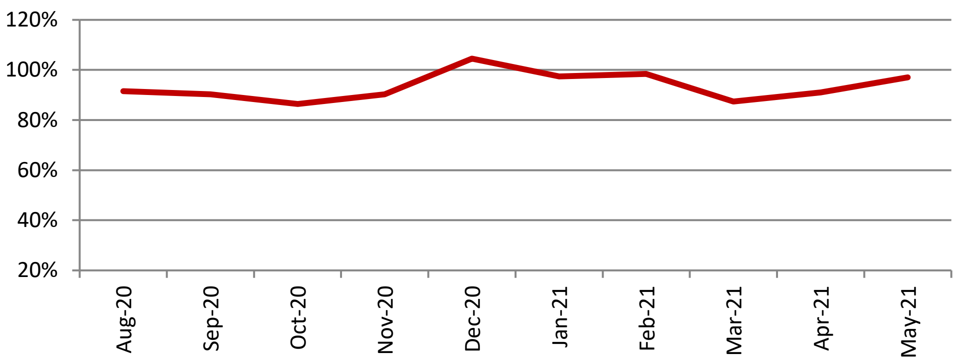
Our recovery of planned care services is strong, and we have delivered a month-on-month improvement in the levels of recovery achieved in outpatients, elective (inpatients and day case) and diagnostic care. This is translating into a reduction in the number of children and young people facing a long wait for care (see section 2.3).

Service area	M1	M2
Outpatients	111%	115%
Inpatients & day case	105%	107%
Diagnostics	91%	97%





Radiology Activity Recovery



This level of recovery will mean we are eligible to receive additional funding though the elective recovery fund.

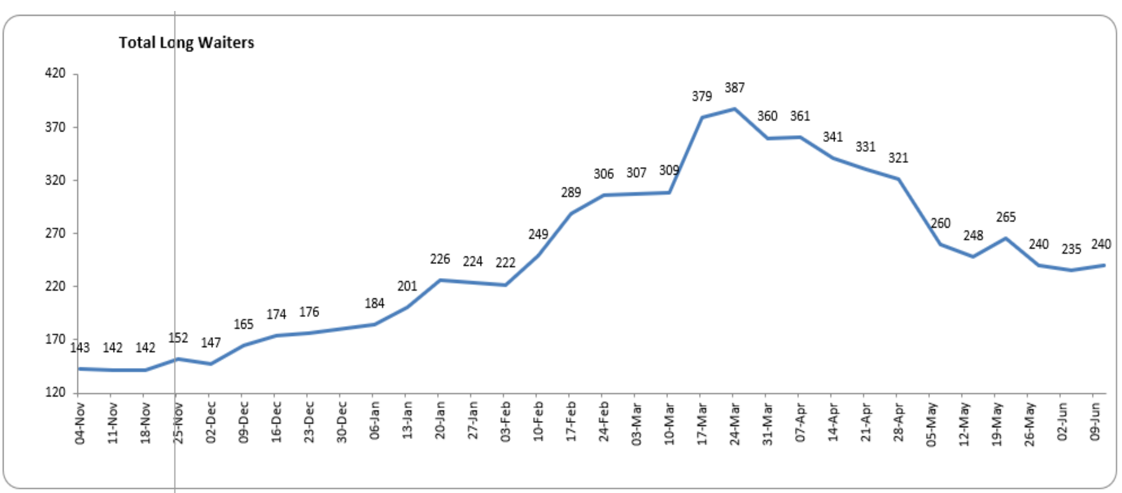
2.2 Paediatric Accelerator Programme

Alder Hey is a member of the specialist children's hospitals national accelerator programme. We will utilise the additional investment to accelerate the treatment of more children and young people. The table below summarises the number of children and young people who we expect to benefit from receiving their treatment sooner.

	Additional IP activity funded by the accelerator	Additional OP activity funded by the accelerator	TOTAL additional activity funded by the accelerator
Alder Hey	426	3,418	3,844

2.3 Waiting times

The number of children waiting over 52 weeks for treatment on an open referral to treatment pathway reduced from 283 in April 2021 to 235 in May 2021.

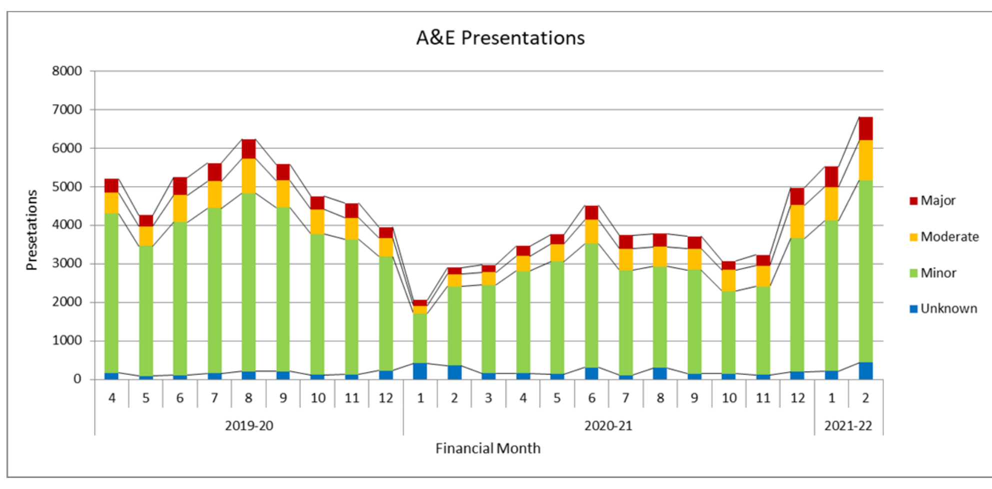


Open pathway RTT performance (18 weeks)	↑ 71.9%
Total number of patients > 52 weeks	↓ 235

We are forecasting an uptick in long wait patients in June and July as we complete the safe waiting list management programme. Nonetheless, in August we expect the accelerator programme will deliver a return to an underlying trend of reducing numbers of patients waiting 52 weeks for treatment.

3. Unplanned care: Emergency Department attendances

The graph below depicts a rising wave of attendances to the ED which began in March 2021 and has grown in May 2021 to be 134% of attendances in May 2019.



Month	Total	Type 1
Apr-20	97.28%	97.28%
May-20	98.14%	98.14%
Jun-20	98.75%	98.75%
Jul-20	97.25%	97.25%
Aug-20	97.79%	97.79%
Sep-20	95.43%	95.43%
Oct-20	96.92%	96.92%
Nov-20	97.51%	97.51%
Dec-20	98.63%	98.63%
Jan-21	98.47%	98.42%
Feb-21	97.89%	97.89%
Mar-21	95.43%	95.43%
Apr-21	92.71%	92.71%
May-21	81.70%	81.70%

A system-wide plan is in development through Gold Command, including support to increase face-to-face appointments in primary care and to support a return to walk-in visits to Walk-in Centres. Internally our plan is focused on five key priority actions:

No.	Action
1	Senior decision making in 60 minutes
2	Establish a Paediatric Urgent Care Stream
3	Protocol to Discharge non-urgent patients with advice
4	Virtual urgent care consultation
5	NHS 111 First Stream

BOARD OF DIRECTORS

Thursday 24th June 2021

Paper Title:	Serious Incident Board Report (1st May 2021 – 31st May 2021
Report of:	Nathan Askew, Chief Nursing Officer
Paper Prepared by:	Cathy Umbers Associate Director of Nursing and Governance

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☑
Background Papers and/or supporting information:	Seven Steps to Patient Safety. National Patient Safety Agency 2004. Health and Social Care Act 2008 (Regulated Activities). Regulation 20 'Duty of Candour'. Serious Incident Framework. Supporting learning to prevent recurrence. NHS England 2015. Serious Incident Framework. Frequently asked questions NHS England 2016. NHS Patient Safety Strategy. NHS Improvement. July 2019. Never Events List (revised February 2021)
Action/Decision Required:	The action required is both to note and approve the report. To note ☑ To approve ☑
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ☑ **The best people** doing their best work ☑ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☑
Resource Impact:	None identified
Associated risk(s):	Managed via risk register

1. Purpose.

The purpose of this report is to provide the Trust Board with an overview and performance position for open and closed incident investigations, that met the serious Incident criteria and reported externally to the Strategic Executive Information System (StEIS),

2. Summary

Table 1 (appendix 1) provides the performance position for StEIS reported incidents including Serious Incidents and Never Events for this financial year. There was one serious incident reported in May 2021 and zero Never Events reported. The table includes the five open investigations carried forward from the previous financial year.

Table 2 (appendix 1) provides an overview of the current open StEIS investigations There are five StEIS ongoing investigations progressing at time of reporting, including one new reported incident. Duty of candour has been completed for all incidents, in line with regulation 20.

Table 3 (Appendix 1) provides an overview of the one closed investigation in reporting period.

Appendix 1

Table 1 StEIS reported Incidents and Never Events performance data 2021/22

Serious Incidents												
Month	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
New	**0**	**1**										
Open (Total)	**5**	**5**										
Closed	**0**	**1**										
Never Events												
Month	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
New	**0**	**0**										
Open (Total)	**1**	**1**										
Closed	**0**	**0**										

Table 2 Open ongoing StEIS reported investigations

StEIS Reference	Date reported	Incident	Agreed date of completion
2021/17300	31/03/2021	Wrong site block. (no harm incident)	30/06/2021
2021/1899	24/01/2021	Unexpected death of a patient (HDU)	25/06/2021
2021/1919	02/01/2020	Patient treatment pathway issue	25/06/2021
2020/23828	09/12/2020	Waiting list data quality issues	23/06/2021
2021/10050	07/05/2021	Management of Deteriorating Patient	05/08/2021

Table 3 closed investigations

StEIS Reference	Date reported	Incident	Comment
2020/16210	26/08/2020	Patient death following brain haemorrhage	Investigation completed and submitted within agreed timeframe. Duty of candour completed in line with regulation 20

END

BOARD OF DIRECTORS

Thursday 24th June 2021

Paper Title:	**Quarter 4 / Year End 2020/21 Complaints, PALS and Compliments report**
Date of meeting:	24th June 2021
Executive Lead:	Nathan Askew Chief Nurse
Paper Prepared by:	Pauline Brown Director of Nursing

Purpose of Paper:	The purpose of this paper is to provide Trust Board with an update and assurance on the performance against complaints and PALS targets in Q4 and full year 2020/21, a thematic analysis of the top reasons for complaints and PALS, action taken as a result of concerns raised, and proposed developments planned in 2021/2022.
Summary and/or supporting information:	There has been an increase in formal complaints received during Q4 (53) compared to Q3 (45), with a total of 156 received in year. This is a significant increase in year compared to 114 in 2019/20. The top reason for formal complaints received in Q4 and in year continues to be treatment and procedures, and the increase is associated with a specific issue in the Neurology service which accounts for 44 complaints received in year. Compliance with the 3 working day acknowledgement for formal complaints is 100% in Q4 with an average of 91% compliance in year. Compliance with the internal Trust target of 25 working day response time is 35% in Q4; this is a slight improvement on 30% compliance in Q3. Whilst this is not an acceptable level of performance, the increase in the number of formal complaints received in Q4 and the actual number of complaints responded to within 25 days was 19 compared to 12 in both Q2 and Q3, and only 8 in Q1 therefore a significantly improved performance in real terms. 6 complaints from across Q2, Q3 and Q4 were responded to as second stage complaints in Q4. In 2020/21, 22 out of 156 formal complaints (13%) progressed to a second stage complaint. The Trust has 1 new referral to the PHSO in Q4 and 1 complaint which continues to be investigated by the PHSO. There has been a slight increase in the number of informal concerns received during Q4 (237) compared to Q3 (223) however a significant decrease in the full year number received: 910 in year compared to 1279 in 2019/20. This is associated with both the decrease in activity in Q1 associated with the pandemic and the establishment of a Family Support Helpline operating a first contact resolution principle. The main reason for informal PALS concerns is regarding appointments and communication.

	Compliance with the 5 day target to resolve informal concerns is 56%. 88 compliments are recorded centrally in the Ulysses system for Q4. The Chief Nurse has commissioned a review of the structure, responsibilities and process for management of complaints and PALS in the Trust to include a central corporate function which will sit within the Patient Experience team. It is expected that this action, together with the additional proposed actions and developments outlined in this report, will lead to a demonstrable improvement in compliance with KPI's, and more importantly a more timely and effective resolution for families who wish to raise concerns. This work commenced in Q3 and will continue during 2021/22
Financial Implications	None
Key Risks Associated	Reputational risk associated with not meeting the quality priorities and the Trust targets.
Quality Implications	Poor patient experience due to not meeting the required time frame for response and resolution
Link To: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	**Delivery of outstanding care** **The best people doing their best work** Sustainability through external partnerships Game-changing research and innovation Strong Foundations
Resource Impact:	Yes
Action/Decision Required:	Trust Board are asked to note the content of this report and support the ongoing Complaints Improvement Plan.

1. Introduction

The Trust is committed to ensuring all our children, young people and their families receive the highest quality of care. However, where care and treatment does not meet the standard of care our service users expect, the Trust has a duty to listen to their concerns, investigate them fully, and provide a full, appropriate and compassionate response. Compliments, concerns and complaints are an important measure of the quality of care we deliver and are used to learn and further improve our services.

This report aims to provide assurance that the Trust is responding to patient complaints in line with its procedures, Department of Health legislation and standards expected by the Parliamentary and Health Service Ombudsman (PHSO).

This report provides an overview of formal complaints and informal PALS concerns received and completed between January to March 2021 (Q4). The report also provides an overarching year-end report for 2020/21; this is a new report with the aim of providing assurance that the Trust is responding to the concerns raised by children, young people and their families in line with Trust procedures, Department of Health legislation and standards expected by the PHSO; identifying and analysing themes more widely that the Trust needs to address to make service improvements; and to highlight action taken.

2. Formal Complaints

2.1 Number of formal complaints

2.1.1 Number of formal complaints received Q4 2020/21

The Trust experienced a significant increase in the number of formal complaints in Q4 2020/21, with 53 submitted compared to 45 in the previous quarter, and 25 in the same reporting period in 2019/20. The increased number of formal complaints has been seen in the Medical Division, associated with an ongoing specific issue regarding the Neurology service and an increase relating to the Emergency Department, and also in the Community Division associated with ASD, as outlined in section 2.2. A comparison of Q4 with the same period last year 2019/20 is shown in Figure 1; Figure 2 shows the breakdown of complaints received by service in Q4.

Figure 1: Number of formal complaints in Q4 2020/21 compared to same period in 2019/20

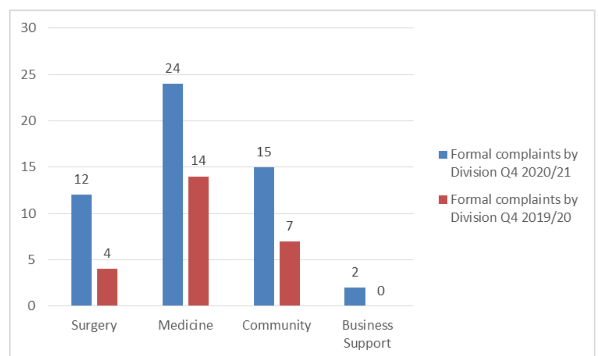
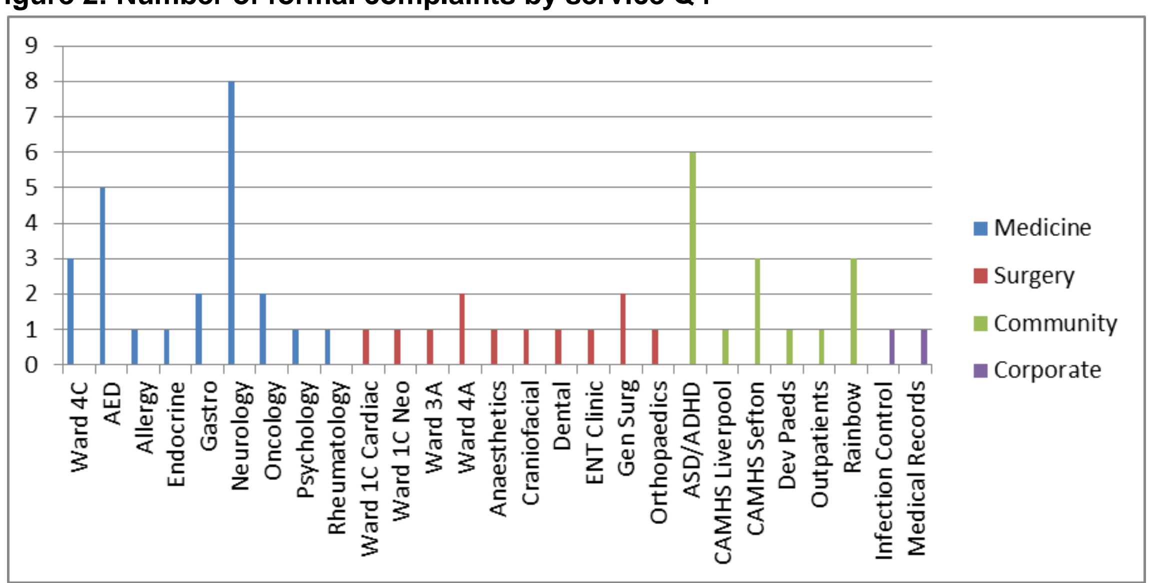


Figure 2: Number of formal complaints by service Q4



2.1.2 Number of formal complaints received in year 2020/21

There have been 156 formal complaints received in 2020/21 as shown in Figure 3. Figure 4 shows the number of complaints by Quarter by Division for the full year

Figure 3: Number of formal complaints 2020/21

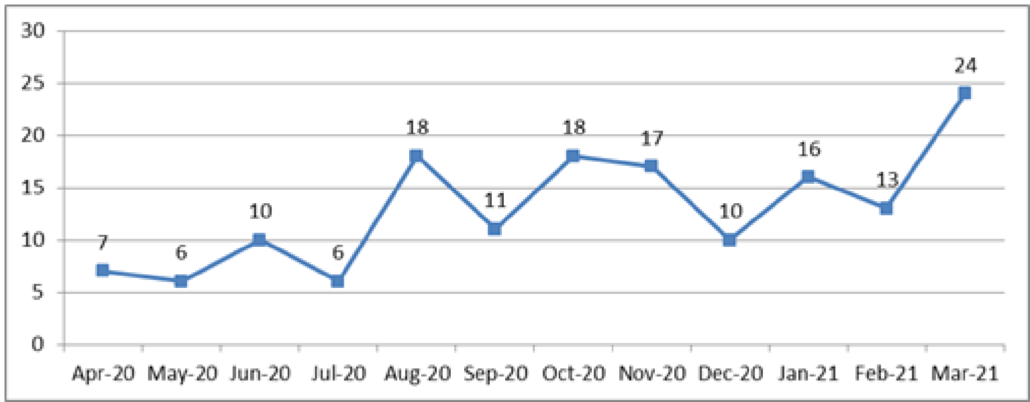
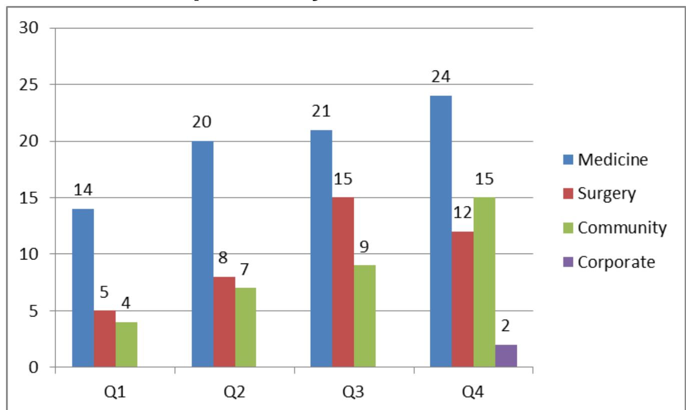


Figure 4: Number of formal complaints by Division in 2020/21



The number of formal complaints has fluctuated significantly in recent years, as shown in Figure 5, and increased by 42 from last year (114 in 2019/20). However, this increase is largely associated with the specific issue in the Neurology service which accounts for 44 complaints received in year. Figures 6, 7 and 8 show the complaints by service for each Division during 2020/21.

Figure 5: Number of formal complaints by year 2013/14 to 2020/21

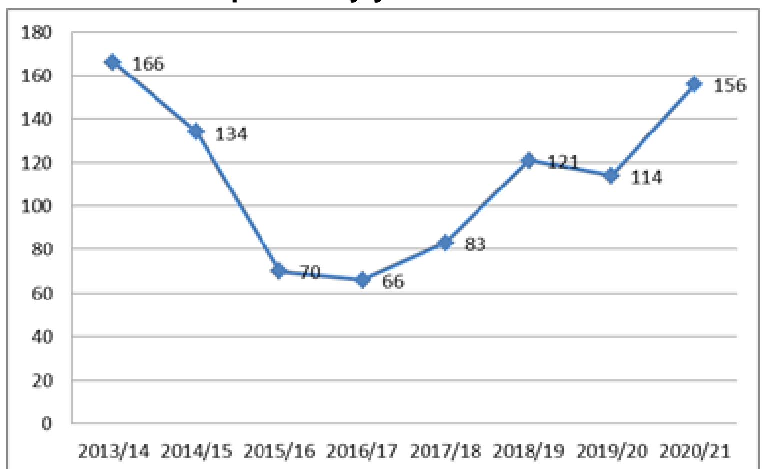


Figure 6: Number of formal complaints by service Medical Division

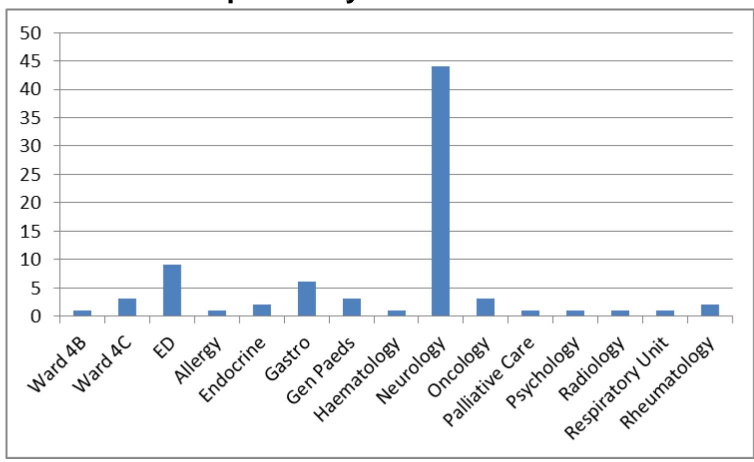


Figure 7: Number of formal complaints by service Surgical Division

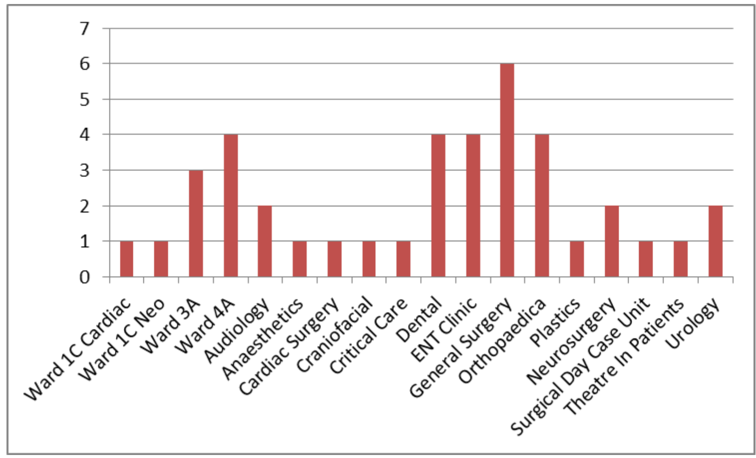
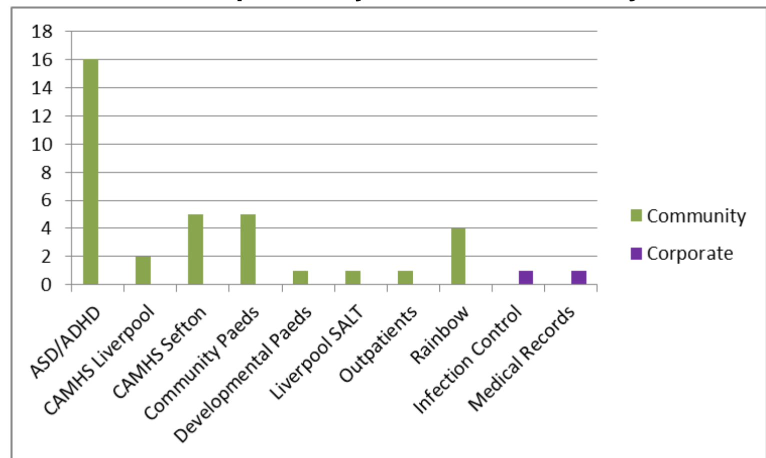


Figure 8: Number of formal complaints by service Community Division and Corporate

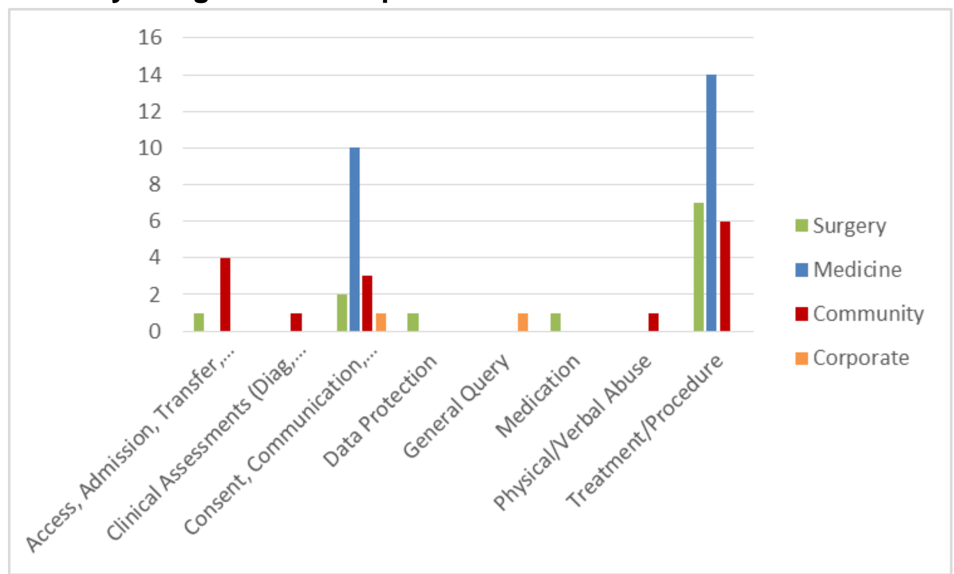


2.2 Complaints received by category Q4 2020/21 and full year 2020/21

Complaints are categorised by subject as set in the Trust Ulysses complaints system. A complainant may raise several issues that the Trust must respond to, and all concerns expressed by families are categorised within the record, however the primary issue is used within this report to monitor key trends.

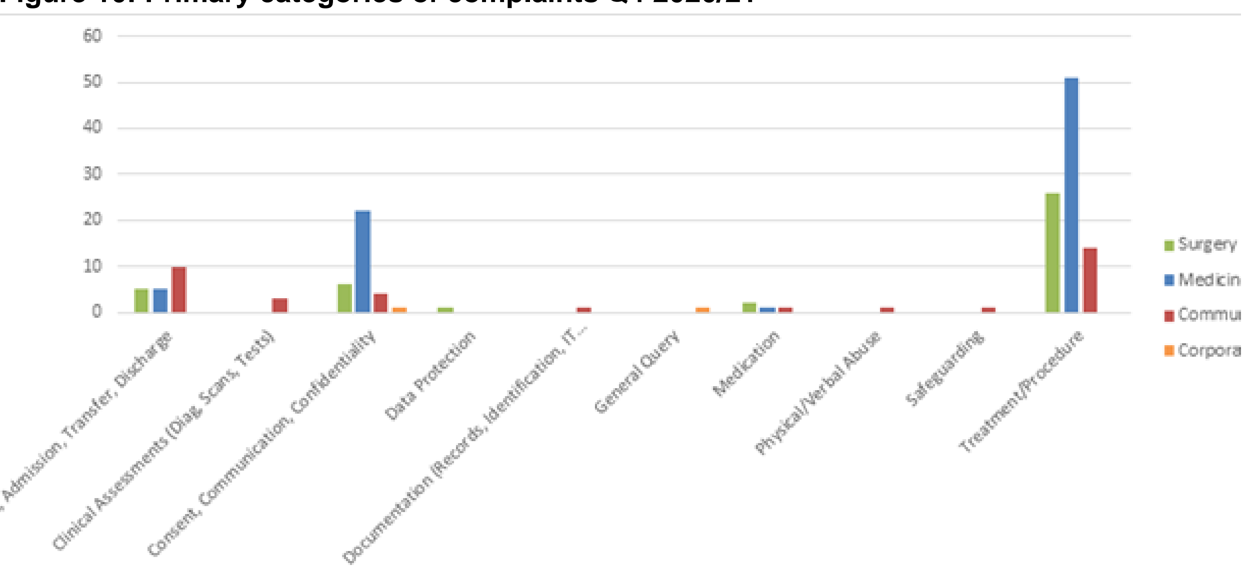
Figure 9 and 10 below demonstrates that the main theme in this quarter and across the full year continues to be in relation to treatment and procedure with a total of 27 complaints (51%) in Q4, and 91 (58%) in year.

Figure 9: Primary categories of complaints Q4 2020/21



NHS
Alder Hey Children's
NHS Foundation Trust

Figure 10: Primary categories of complaints Q4 2020/21



Sub-category identification provides further detail regarding the primary issues raised by families. Figures 11 and 12 demonstrate that the main theme within the treatment and procedure category is in relation to alleged failure in medical care with 18 complaints (33%) in Q4 and 65 complaints (42%) in year. Of these 12 complaints in Q4 (67%), and 45 complaints in year (69%), relate to the Medical Division and are due to the concerns involving the Neurology service regarding the cessation of a service for patients with Tourettes Syndrome.

The specialty and Divisional leadership team continue to work to mitigate parental concerns regarding the discontinuation of treatment regimens for some patients. Complainants are raising common themes within their complaints and several have referred to an online petition regarding the commissioning of a service for this patient group. The Medical Division have worked with each case to provide a tailored response, assessing each child's individual clinical need.

Figure 11: Sub categories of complaints Q4 2020/21

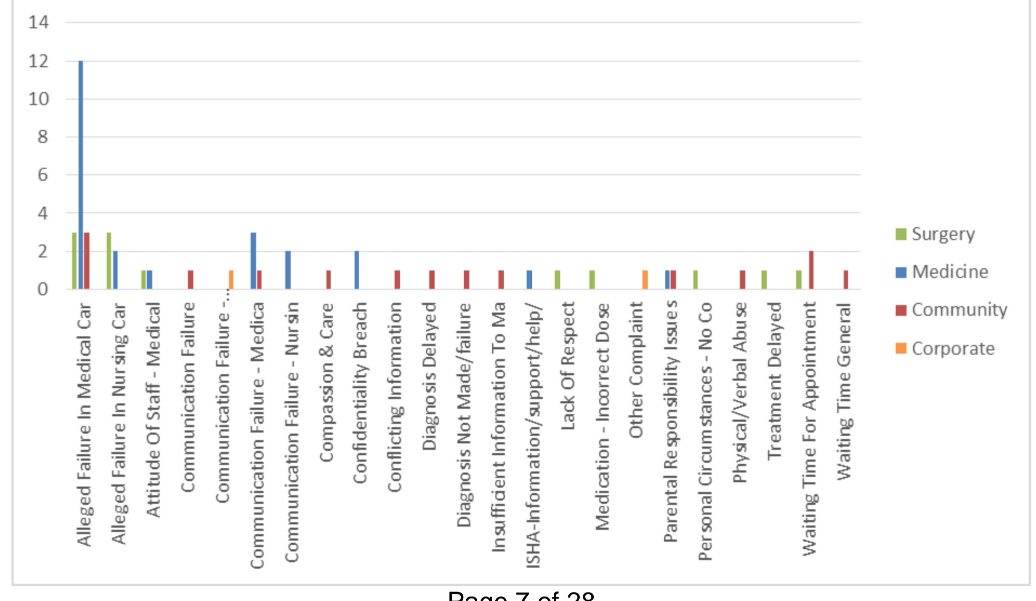
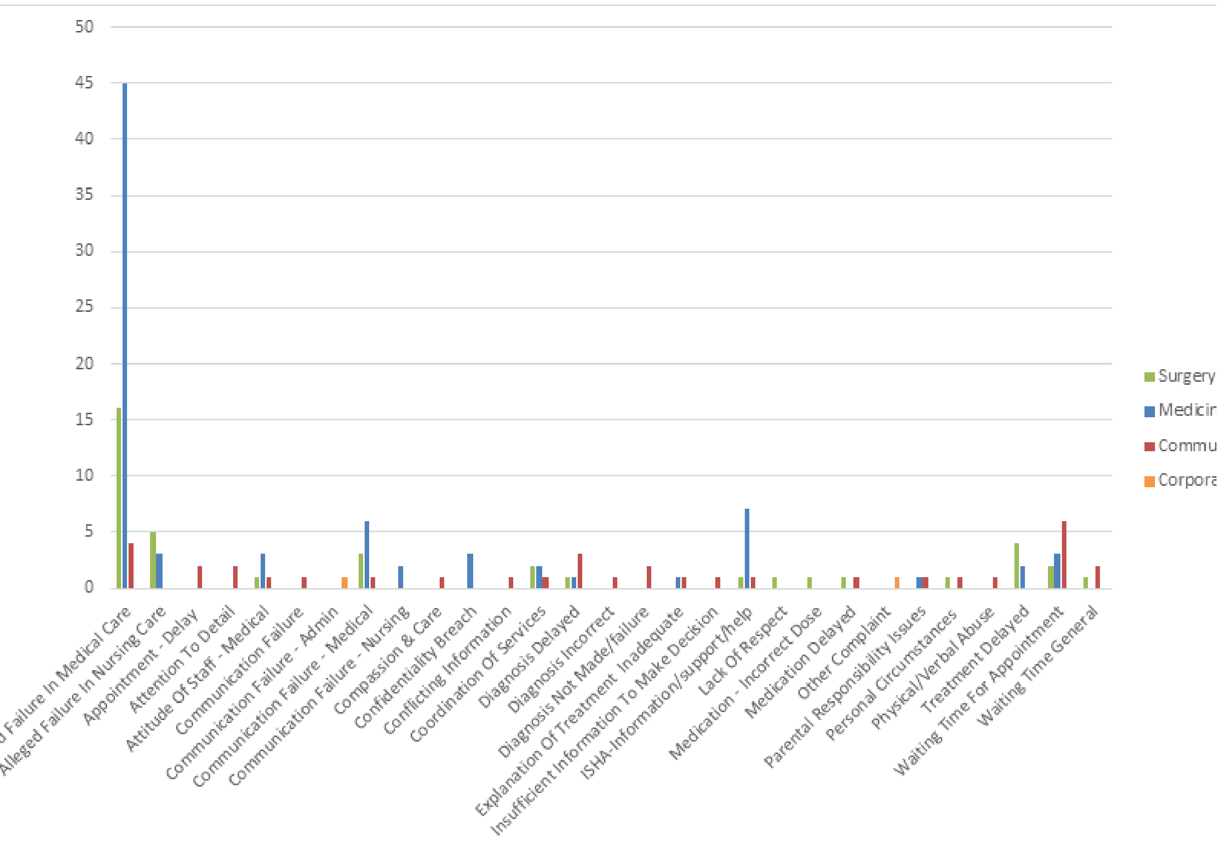


Figure 12: Sub categories of complaints in year 2020/21



A review of the Ulysses complaints module is underway which includes a review of the categories to ensure they are in in line with the NHS Digital complaints categorisation.

2.3 Trust performance against Key Performance Indicators (KPI)

2.3.1 National context

In response to the coronavirus pandemic, in April 2020 NHSE/I supported that Trusts could suspend investigation of new complaints. However, throughout the pandemic, the Trust has continued to be to respond to complaints in line with RM6 Complaints and Concerns policy. New investigations continued, with no suspended new cases, however the timescale to respond was negotiated with the complainant where the investigation was impacted upon by the pandemic response.

Current national guidance has set out that Trusts must continue to comply with NHS Complaints Regulations, however acknowledge that in some settings it may take longer to respond to a complaint and consider it currently permissible for this to go beyond the usual six month maximum time period. However, organisations should opt to operate as usual regarding the management of complaints if they are able to do so. The Trust continues to aspire to responding to complaints in line with RM6 Complaints and Concerns policy.

2.3.2 Compliance with 3 day acknowledgement 2020/21

The NHS Complaints Guidance (updated January 2021), sets out that complaints should be formally acknowledged within 3 working days; reflected in the Trust policy (RM6 Complaints and Concerns policy). The Trust has a generic formal complaint acknowledgement letter that is sent out to the complainant; this includes a named contact for the complainant to contact should they require to do so (including the direct phone number) and the date the response is expected to be with them. The letter also includes information relating to the services offered by Healthwatch Advocacy. The Complaints Officer may also telephone the complainant to discuss their concern further.

In Q4, 100% of formal complaints received were acknowledged within 3 working days, with 43 (81%) being acknowledged on the same day. This is a dramatic improvement in performance exceeding the Trust target at a time with the highest number of complaints. Figure 13 below shows a breakdown of acknowledgment times providing the Trust assurance with continued high compliance with the standard.

Figure 13: Compliance with 3 day acknowledgement Q4 2020/21

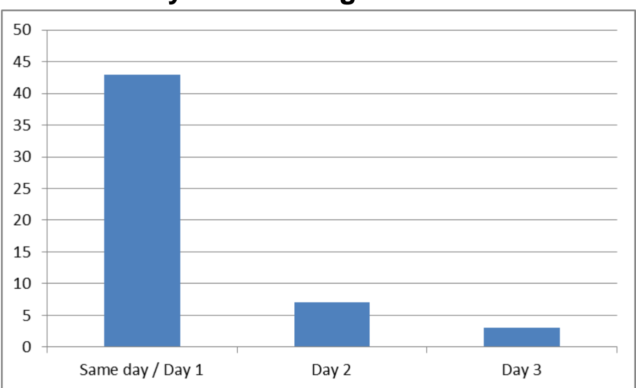


Figure 14 shows the percentage compliance by Quarter, and Table 1 shows the compliance by number demonstrating increased compliance with this standard.

Figure 14: Compliance with 3 day acknowledgement in year 2020/21

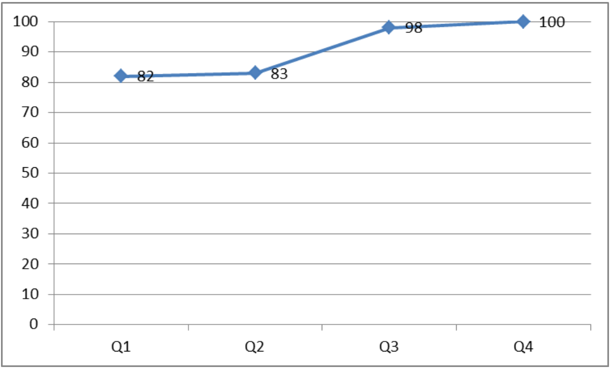


Table 1: Compliance with 3 day acknowledgement	Total number of complaints received in Quarter	Total number acknowledged within 3 working days	% number acknowledged within 3 working days
Q1	23	19	82%
Q2	35	29	83%
Q3	45	44	98%
Q4	53	53	100%

2.3.3 Complaints responded to and closed in Q4 2020/21

A total of 41 complaints were responded to and closed in Q4 of which 24 were received during Q4; 16 were received in Q3; and 1 was received in Q2. The complaint received in Q2 was received by the Medical Division in relation to the alleged failure of Medical care in ED and took 117 days to close due to the complexity of the complaint.

2.3.4 Compliance with 25 day response

Whilst the NHS Complaints Guidance states that there is no set timeframe to respond to a formal complaint, as this is dependent on the nature of the complaint, the Trust has set an internal timeframe in the Complaints and Concerns policy to respond to formal complaints within 25 working days. Where a complaint is complex and / or multi organisational, this is discussed with the complainant to negotiate an extended timeframe with them and agree a new date for response. A meeting with appropriate Trust representatives is also offered as this is can lead to a successful resolution of the concerns raised.

24 of 53 complaints received in Q4 were responded to during the same quarter. The response times are illustrated in Table 2 below and Figure 15 demonstrates that 19 (35%) of complaints were responded to within 25 days; this is a slightly improved performance compared to Q3. It is recognised that improvement work related to complaints performance needs to continue.

Table 2: Compliance with 25 day response Q1-4 2020/21

	Total complaints received in Quarter	Complaints received and responded to in same Quarter	0-25 days	26-35 days	36-45 days	46-55 days	56-65 days	66-75 days	76-99 days	More than 100 days
Q1	23	12	17 (74%)	3 (14%)	1 (4%)			1 (4%)	1 (4%)	
Q2	35	18	12 (34%)	13 (37%)	5 (14%)	2 (6%)	2 (6%)			1 (3%)
Q3	45	27	12 (27%)	24 (53%)	2 (4%)	3 (7%)	1 (2%)	1 (2%)		2 (5%)
Q4	53	24	19 (36%)	17 (32%)	11 (21%)	4 (7%)	1 (2%)	1 (2%)		

Figure 16: Comparison of complaint number with 25 day response Q1-4 2020/21

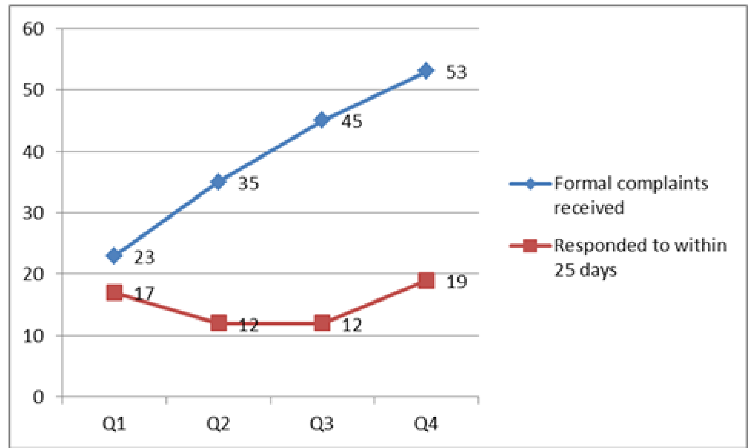
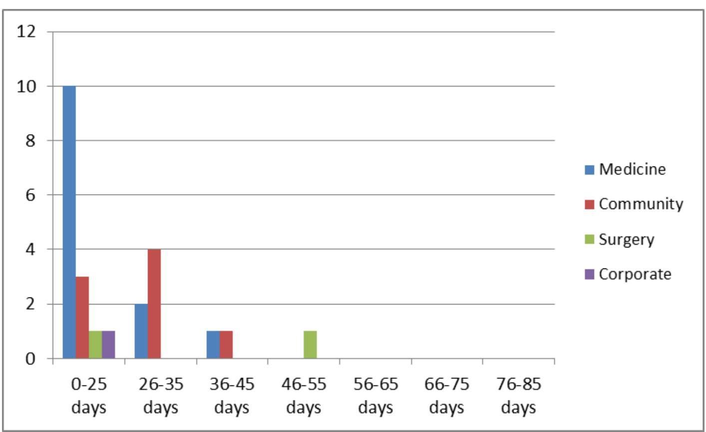


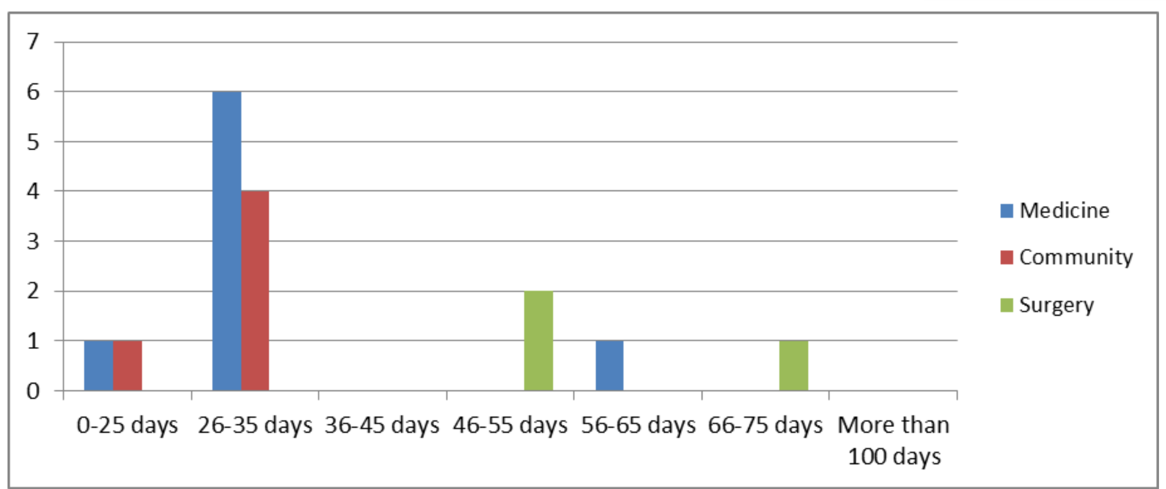
Figure 17 demonstrates the compliance with the 25 day response by Division related to complaints received and responded to within Q4.

Figure 17: Compliance with 25 day response – complaints received and responded to in Q4



Of the 53 complaints received during this period, 7 have ongoing investigations however they have all exceeded the 25 working day response time (1 in Medicine; 6 in Surgery).

Figure 18: Compliance with 25 day response by Division – complaints received in Q3 and responded to in Q4



2.3.4 Number of open and closed formal complaints by month

The reporting of open and closed complaints by month is an addition to the complaints report as requested by the Trust SQAC Board Assurance Committee. As such, data for 2019/20 is also included as Appendix I as a comparative measure.

Table 3 shows there were 156 formal complaints opened in 2020/21 and 146 closed. The number of open complaints is inclusive of second stage complaints.

Complaints that are received in a month may not be responded to until the next month in line with the 25 day response timeframe.

Table 3: Formal Complaints received 2020/21													Cumulative to date
Month	**April**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	
New	7	6	10	6	18	11	18	17	10	17	13	24	**156**
Open	*23	19	20	15	28	24	30	31	23	28	27	38	
Closed	9	10	9	11	5	15	12	16	18	11	16	14	**146**
Second stage	1	1	2	2	2	2	4	1	1	2	1	3	**22**

Note* 25 complaints carried over from the previous financial year 2019/20

Delays in completion of responses have on occasion been a result of complex complaints. Delays have also been caused where corporate quality check of the complaint has identified that further work is required by the associated Division to ensure that the complaint response fully answers the concerns raised, demonstrates compassion, apologises, and identifies what action will be taken as a result of the learning from the complaint; some responses have required multiple corporate quality checks to ensure they attain the expected standard.

The increased number of complaints received in Q4 has also been identified as a reason for responses being delayed, however despite receiving the highest number of complaints

within Q4, the Medical Division achieved the highest response rate. The Surgical Division have had a gap in Complaints Officer however this has been resolved from March 2021.

There is absolute recognition by the Trust and the Divisions that it is essential that complaints are responded to in a comprehensive and timely manner and the current response times are not considered acceptable.

The Chief Nurse has commissioned the Director of Nursing to undertake a full review of the structure and process for responding to complaints, including corporate and divisional roles and responsibilities relating to complaints management and this review has commenced in collaboration with Divisional leads and the Trust Patient Experience lead. The aim is that once established, implemented and embedded there will be an improving trend of responding to complaints within the Trust timescale of 25 days demonstrated in 2021/22. A comprehensive Complaints Improvement Plan has been devised and is monitored through CQSG on a monthly basis.

The new process will include a procedure whereby any request to extend the investigation and response period is reviewed and authorised by the Chief Nurse in the first instance before discussing the response timeframe with the family. Future Complaints Report will then be in a position to provide greater assurance and oversight of complaints that have an agreed extended response and those that have not been authorised and are in breach of our standards. This will provide further trend analysis and enable targeted improvement work to be identified and undertaken.

The Chief Nurse and the Medical Director have established a monthly investigation performance review with each Division where the management of complaints will be further monitored and supported.

2.3.5 National complaint reporting: KO41a return

The Trust is mandated to submit data nationally regarding the status, categories and outcome of complaints on a quarterly basis to NHS Digital using the Hospital and Community Health Services Complaints Collection (KO41a) tool.

The information obtained from the KO41a collection monitors written complaints received by the NHS. It also supports the commitment given in equity and excellence to improve the patient experience by listening to the public voice.

For assurance, Q3 data was submitted in April 2021 and Q4 data was submitted in May 2021.

2.4 Outcome of the complaint

2.4.1 Complaints upheld

The outcome of each complaint response is reviewed and assigned by the Chief Nurse or deputy. In Q4 14 (34%) of complaints were not upheld; 13 (31%) were partially upheld, and 14 (34%) were fully upheld. A complaint will be partially upheld if any one concern raised is

upheld irrespective of whether the majority of concerns in a complaint are not upheld. This is a significant marker of an open, transparent and learning organisation. Figures 19, 20 and 21 show the outcome of complaints by Division. Figure 22 shows the full year position with 41% of complaints fully upheld.

Figure 19: Outcome of 24 complaints closed in Q4 received in Q4 2020/21

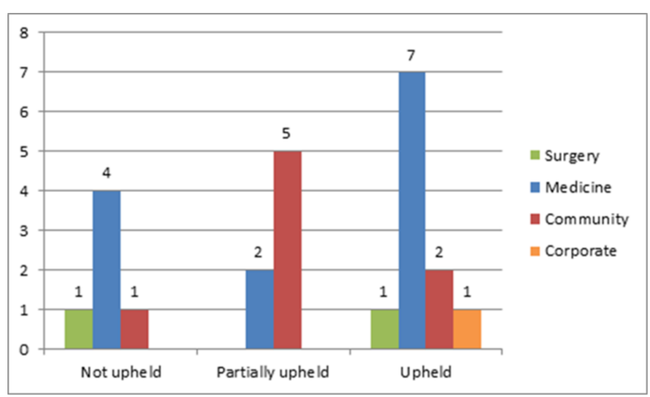


Figure 20: Outcome of 16 complaints closed in Q4 received in Q3 2020/21

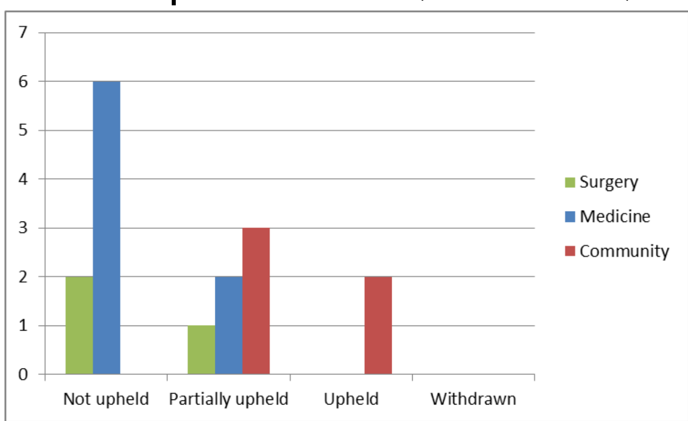


Figure 21: Outcome of 1 complaint closed in Q4 received in Q2 2020/21

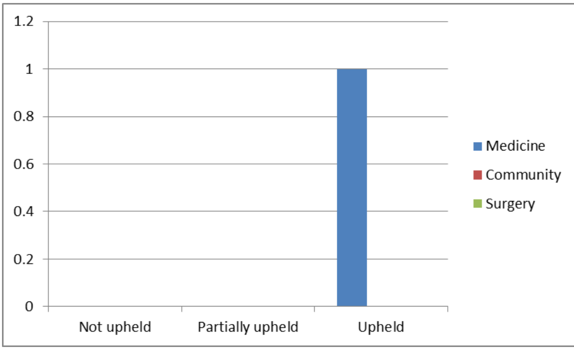
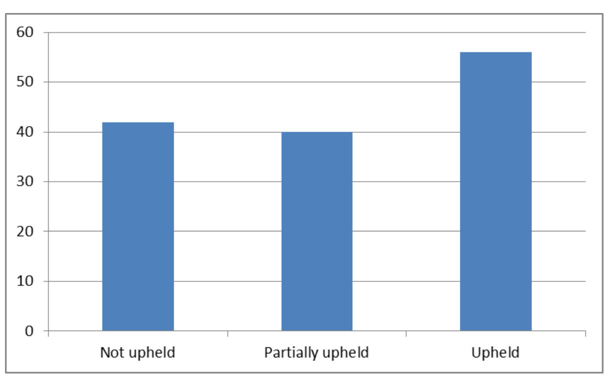


Figure 22: Outcome of complaints in year 2020/21



2.4.2 Second stage complaints

Second stage complaints are a rich source of valuable data and a key indicator of our performance. They can be triangulated to inform the Trust of how satisfied our families are with the quality of our response, and as an early indicator of families who may seek further resolution through the Parliamentary & Health Service Ombudsman. Second stage complaints are monitored on a monthly basis as a key performance indicator.

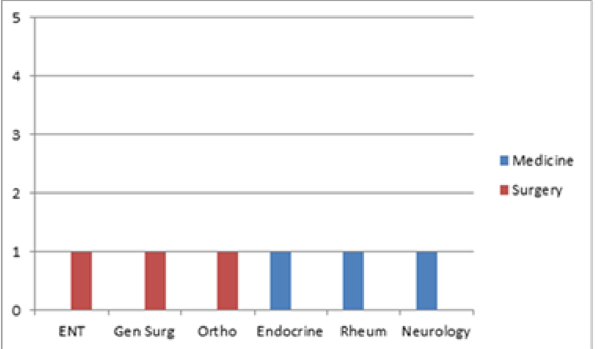
The initial response letter advises the complainant that, should they be dissatisfied with any part of the initial complaint response, or require further assistance, they should contact the Trust within 25 working days in order that the Trust can try to resolve any outstanding concerns.

In Q4, 6 families informed us that they were not satisfied with the outcome of their initial complaint response: 1 received in Q2 and responded to in Q3; 2 received in Q3 and responded to in Q4; and 3 received and responded to in Q4.

Families have been dissatisfied either because they felt the response did not answer their questions fully or because they disagreed with our response.

The 6 cases were investigated and responded to as second stage complaints; 5 have been closed and resolved to the satisfaction of the complainants; 1 complaint received in Q4 remains open and under continued investigation. The outcome of the 5 complaints closed did not change following further review and investigation (2 not upheld; 4 partially upheld).

Figure 23: Q4 Second stage complaints by service



22 second stage complaints were received in 2020/21 of which 2 relate to Q4 of 2019/20. Therefore, at the time of reporting 13% (20 out of 156) complaints responded to in 2020/21 resulted in a second stage complaint. Whilst this indicates an overall high level of satisfaction with the quality and content of the initial complaint response, there is a need to monitor and review the reasons why families remain dissatisfied in order to ensure our investigations, responses and actions are appropriate and of the highest standard for our families.

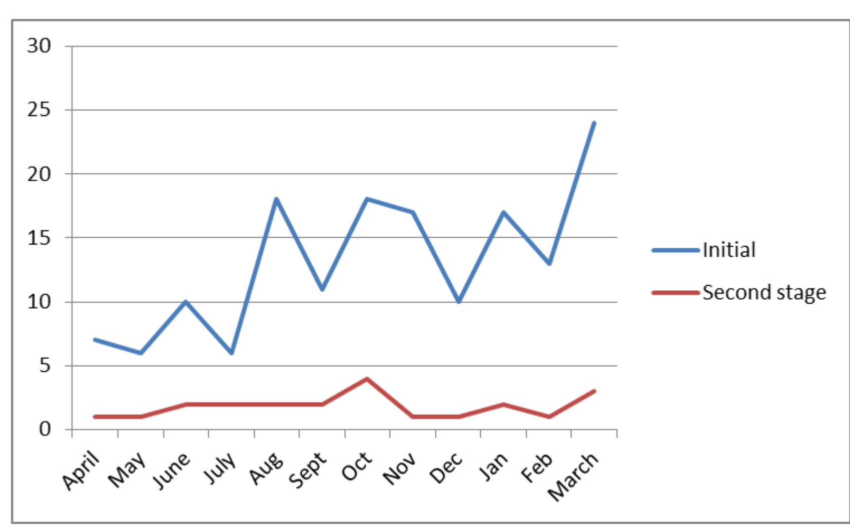
Table 4 below shows the number of second stage complaints received within 25 working days in 2020/21; 5 of the 22 (22%) were received 47-100 working days after the initial response, demonstrating that the Trust continues to work in partnership with families to try to address outstanding concerns despite being outside of the timeframe.

Table 4: second stage complaints received

Q	Total complaints received in Quarter	Total second stage received in Quarter	Number of days between initial response sent and second stage received (advised 25 days)					
			within 25 days	26-40 days	41-60 days	61-80 days	81-100 days	More than 100 days
Q1	23	4	1			2		1
Q2	34	6	5		1			
Q3	45	6	6					
Q4	53	6	5			1		

As second stage complaints may not necessarily fall within the same Quarter, they cannot be displayed in accurate percentage terms by Quarter. However Figure 24 shows the comparison of monthly initial complaints and monthly second stage complaints received.

Figure 24: Comparison of initial formal complaints against second stage complaints 2020/21



Figures 25 and 26 show the breakdown of Divisional second stage complaints by month and by speciality demonstrating that the highest number relate to families dissatisfaction with the cessation of the Tourettes service.

Figure 25: Second stage complaints by month

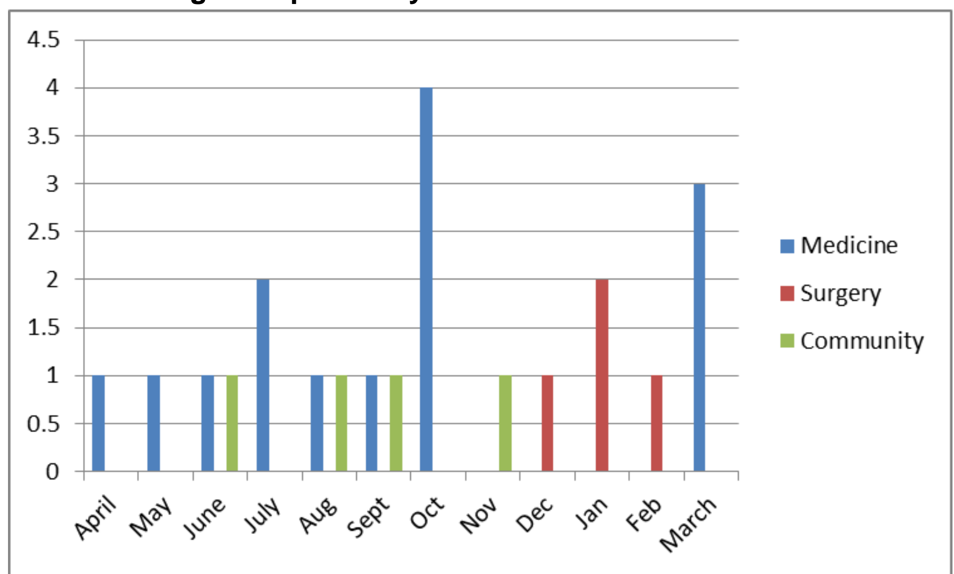
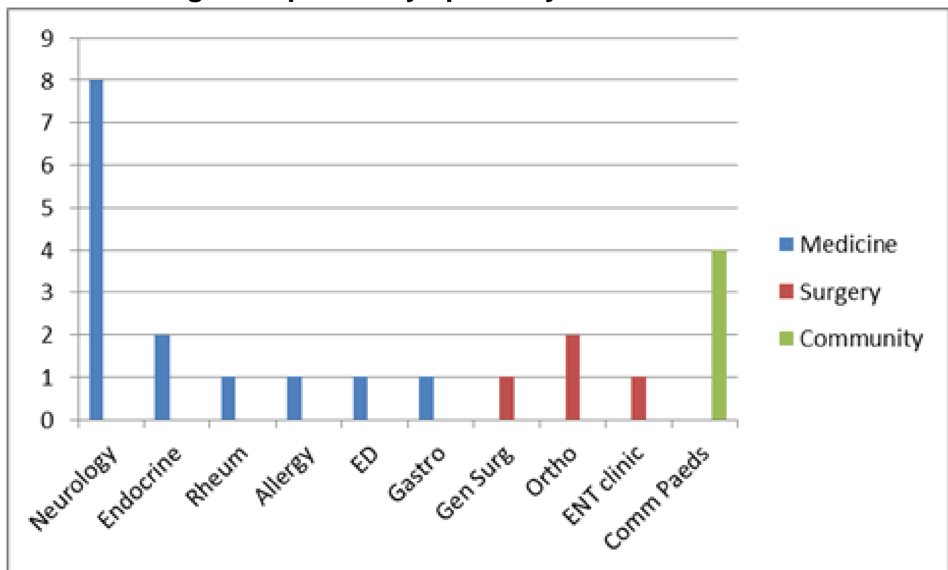


Figure 26: Second stage complaints by speciality



2.5 Referrals to Parliamentary & Health Service Ombudsman (PHSO)

There was one new referral to the Parliamentary & Health Service Ombudsman during this period related to a complaint in the Medical Division. There is one ongoing investigation related to the Surgical Division.

2.6 Actions and learning from complaints

Complaint Officers log actions and learning within Ulysses however the system requires significant development to enable actions to be pulled into an action log which can be monitored and tracked to completion; currently this requires manual input which is resource and labour intensive.

Formal complaints are reviewed at the monthly Divisional Integrated Governance meetings to ensure senior divisional oversight of the current trends, to enable learning, to enable identification of specific areas of concern and any strategic actions, and ensure actions are fully disseminated, implemented and reviewed. Updates are shared by the Divisions at the Clinical Quality steering Group (CQSG) each month to ensure Trust wide learning.

Examples of improvements made to services as a result of concerns raised are:

Medical Division:

Concern: Communication failure: nobody returned mother's calls or replied to her emails. Mother believes admission could have been prevented had she been contacted

Action: Discussed with the administrative and clinical teams. Task and finish group has been set up to review and improve communication processes. This will ensure a standardised approach across the Division and ensure patients and families are responded to appropriately

Concern: Alleged failure in Medical Care: Father unhappy with clinical reviews and with the delay in his daughter receiving a review. Staff attitude: PCO was unhelpful during a telephone conversation

Action: A clinical review scheduled for the patient. Discussed concern with the PCO's and secretarial team and reinforced the importance of resolving the concern informally before referring to PALS

Community Division:

Concern: Confrontation in outpatients between two families - not all visitors in Outpatients wearing facemasks causing concern for other visitors. Not all staff in Outpatients aware of how to contact Security if situation in Outpatients escalates and Security are required

Action: Signage in Outpatient waiting areas reviewed and updated. Location of panic buttons in Outpatients shared at Outpatients safety daily huddle

Concern: Father not routinely copied into letters or appointments. Father felt his perspective was missing from clinic letter as he was not invited to the appointment

Action: Escalated to IT Department who are reviewing the system to allow letters to be sent automatically to more than one parent. Meeting arranged and held between to review the clinic letter and add additional information from the father

Concern: Family informed a letter had been sent out by the Trust which they did not receive

Action: Guidance provided to the administrative team that they need to create a letter that is linked to the address book in the MediSec system for writing and storing letters

Surgical Division:

Concern: Delay Transit Study, delay due to NHS Covid restriction and family issues

Action: Appointment rescheduled

Concern: Family did not feel staff on Burns Unit could address their Cleft Post-Op concerns

Action: Burns unit nursing staff reminded to escalate any issues to cleft team

Concern: Parental concern relating to waiting time for appointment / arrangements for day case investigations

Action: Appointment offered and plan for the day case admission discussed with parent, assurances offered and Matrons direct contact details provided

Corporate:

Concern: Delayed sharing of pre-adoptive health record with parent due to Trust understanding of the NHS guidance regarding the management of pre adoptive records.

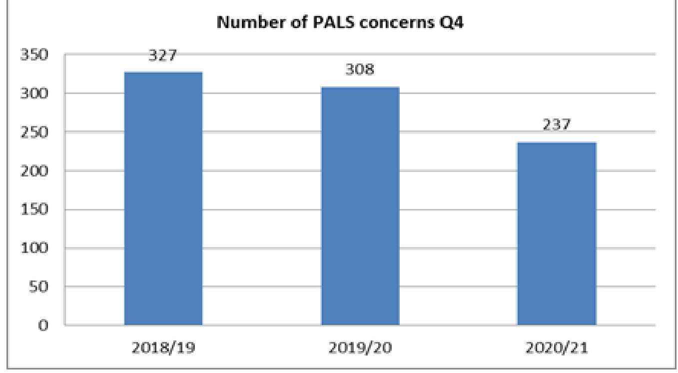
Action: Task and finish group set up to review the Trust process for handling adoptive records to ensure that going forward the handling of adoption records will be processed in line with national guidance as recognised process requires improvement. The complaint and action will be reviewed at the Trust Information Governance Steering Group Committee to monitor actions and share learning.

3. PALS informal concerns

3.1 Number of informal PALS concerns received Q4 2020/21

There were 237 informal concerns received during Q4, a slight increase of 14 from the previous Q3 when there were 223 reported, and a reduction of 71 compared to the 308 reported in the same period in Q4 2019/20, as shown in Figure 27

Figure 27: Number of PALS in Q4 2020/21



3.2 Number of informal PALS concerns received in 2020/21

The PALS service has been fully operational during the pandemic although the front facing office has been closed. The Family Support helpline was established as part of the Trust pandemic response as many families had enquiries and concerns they needed assistance with, and call handlers have been able to resolve a large number of issues and enquiries immediately thus negating informal PALS concerns or formal complaints being raised. PALS issues raised through the telephone support line are escalated to the relevant Division to support, contact and investigate with the concerned family member.

Whilst the PALS office was closed for families to raise concerns face to face between April to December 2020 (Q2-Q3), clear posters were displayed advising how concerns could be raised, in addition to information on how to raise a concern available on the Trust website. The PALS office has been fully Covid risk assessed and re-opened from January 2021 with appropriate infection control measures taken.

There were 910 informal concerns received during 2020/21 which is a significant reduction of 369 compared to 1279 reported in 2019/20. This decrease in contacts is due to the impact of the pandemic in Q1 resulting in a reduced volume of patients accessing our services, and also in part due to the establishment of the Family Support telephone helpline operating a first contact resolution principle. Figure 28 below shows this is the lowest number of informal concerns in eight years.

Figure 28: Number of PALS concerns 2020/21

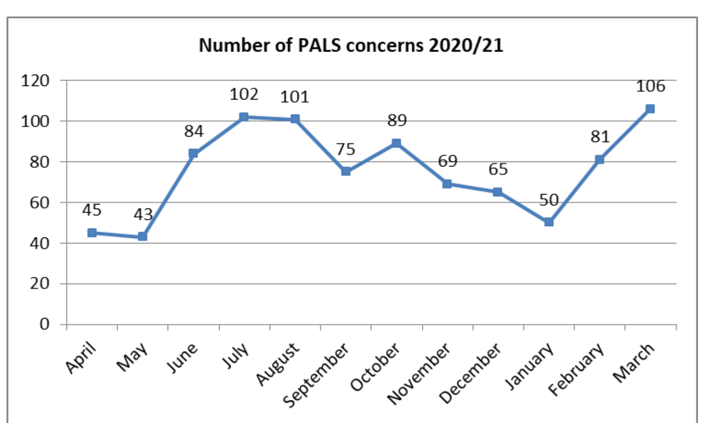


Figure 29: Number of informal concerns by year 2013/14 to 2020/21

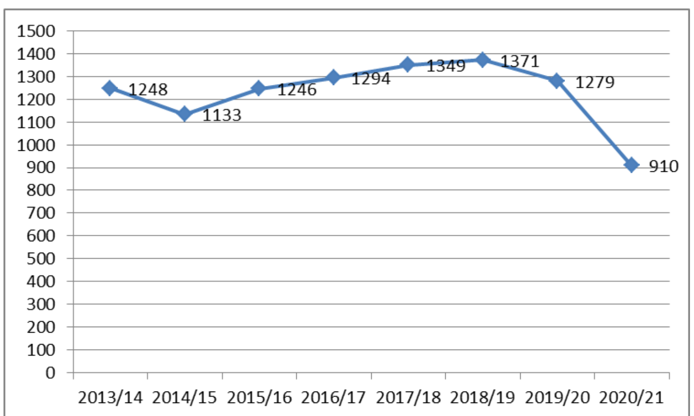
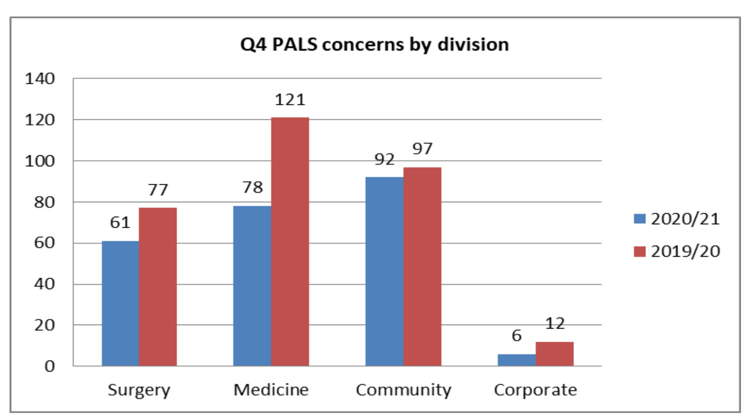


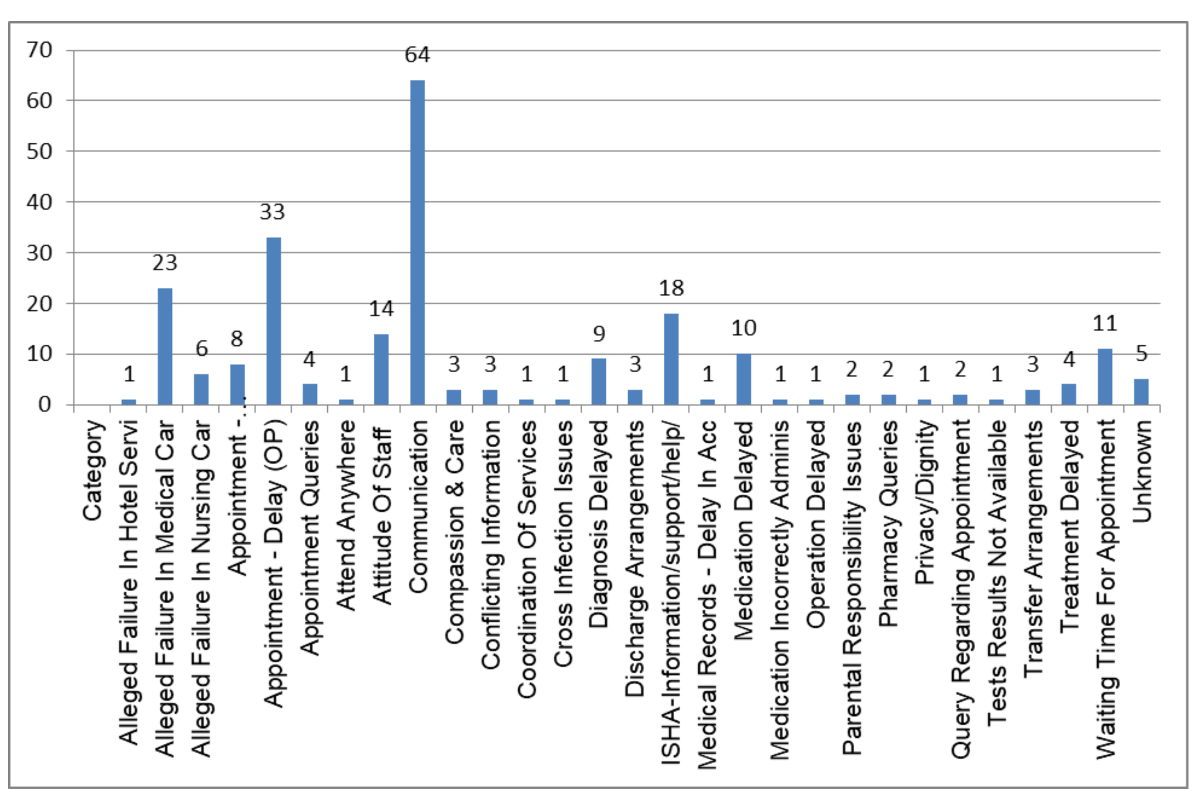
Figure 30 below shows the number of informal PALS concerns by Division in Q4 2020/21 compared with the same period in 2019/20; demonstrating a reduction in all Divisions.



3.2 Informal PALS concerns received by category Q4 2020/21

All informal PALS concerns are categorised by subject using the same system as formal complaints, which assists with data analysis and monitoring. The main issues raised within Q4 continue to relate to communication, appointment waiting times, and alleged failure in Medical care as shown in Figure 31. These continue to be the highest three themes however there is a significant reduction in appointment concerns in comparison to Q3 and a significant increase in communication issues.

Figure 31: Categories of informal PALS concerns Q4



As described above, a significant improvement for families wishing to raise an enquiry or needing support has been through the establishment of the Family Support helpline initially set up as a pandemic helpline. In Q4, 1674 calls were received, a decrease of 424

compared to the 2098 calls received in Q3; this figure is inclusive of any informal PALS concern raised by telephone. The call line is currently staffed by members of the Patient Experience team who are shielding or the Concierge staff. The call line currently operates from 0900-1800 Monday to Friday and 0900-1500 at the weekend, providing increased accessibility for our families needing help, and has responded to an average of 140 calls per week. It is acknowledged that a proportion of these calls will have been made to different services within the Trust prior to establishing the helpline however families have fed back that the central point of contact has been useful in ensuring their call is directed appropriately as required.

Figure 32: Number of calls to the helpline 2020/21

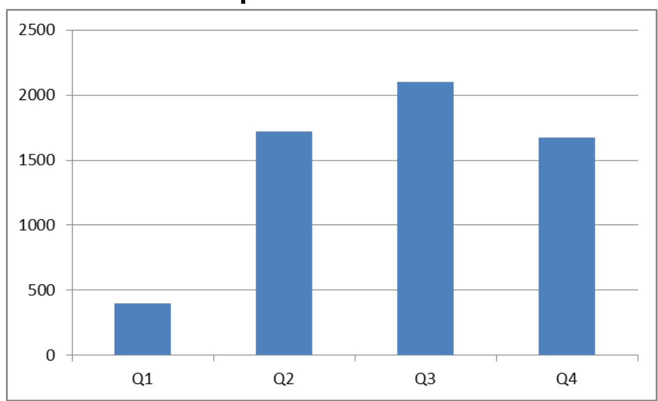
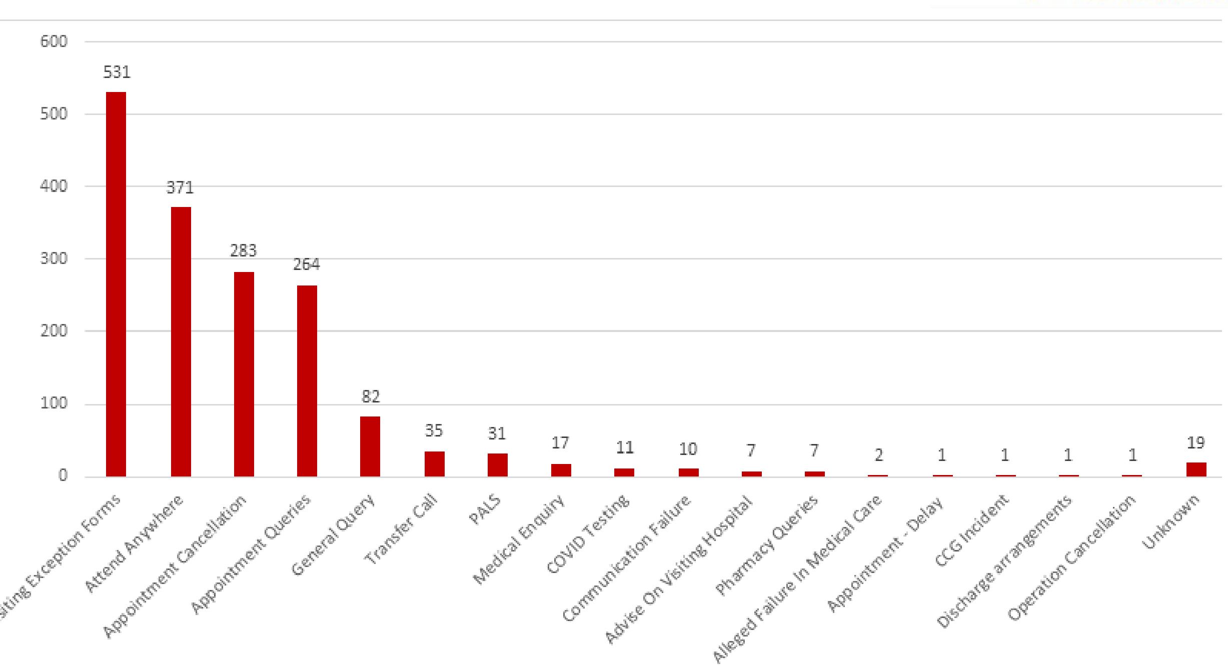


Figure 33 shows that 918 families contacted the Trust for help, support and advice in relation to appointments (264 appointment queries, 283 related to cancelled appointments, and 371 regarding Attend Anywhere). Triangulation of this data with the PALS numbers (11 waiting time for appointment and 33 delays) demonstrates that this is the highest contact reason for families. The Patient Experience Team are working in collaboration with the Community Division Outpatient Department senior leadership team to review the most appropriate model to respond to appointment enquiries or concerns.

Advice and access to Visiting Exception forms remains the second highest reason for call to the helpline (531 in Q4; 516 Q3); these forms have been introduced to assist with visiting arrangements which has been restricted due to covid regulations.

Figure 33: Categories of calls to the Family Support telephone helpline



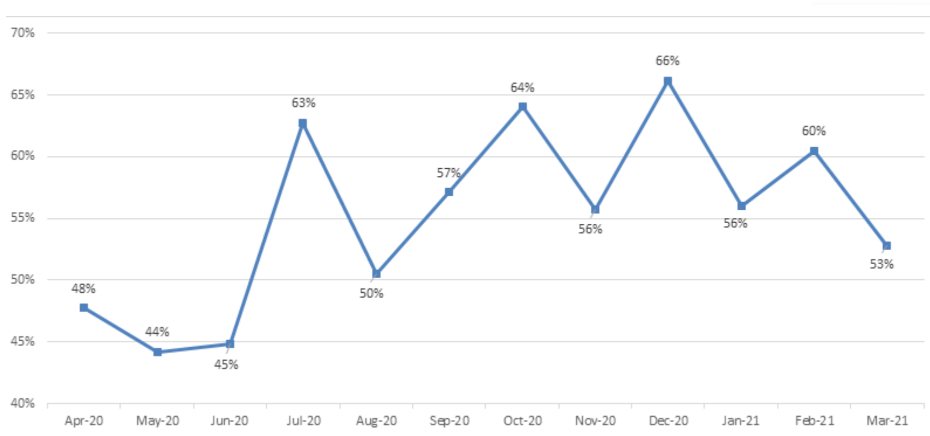
3.3 Trust performance against Key Performance Indicators (KPI): compliance with 5 day response

The PALS and Complaints teams endeavour to respond to concerns within the 5 day timeframe in order to try and obtain quicker resolution for children and young people. For Q4, the KPI of 90% of concerns responded to within 5 days was not met, with only 56% of PALS reported to be concluded within this time period as recorded within the Ulysses system and shown in Table 5 below.

Table 5: Compliance with 5 day response to PALS concerns			
PALS	**Received Q4**	**Q4 5 day response**	**Q4 overdue**
Surgery	61	28 (46%)	33 (54%)
Medicine	78	40 (51%)	38 (49%)
Community	92	60 (65%)	32 (35%)
Corporate	6	5 (83%)	1 (17%)
Total	**237**	**133 (56%)**	**104 (44%)**

Figure 34 below shows the compliance by month in 2020/21 demonstrating that the Trust has not met this standard.

Figure 34: Percentage compliance with the 5 day response to informal concerns



In order to improve compliance, and resolve concerns in a timely way for children, young people and their families, the Chief Nurse has commissioned the Director of Nursing to undertake a full review of the structure and process for responding to PALS, including corporate and divisional roles and responsibilities relating to the management of concerns. This review has commenced in collaboration with Divisional leads and the Trust Patient Experience lead. The aim is that once established, implemented and embedded there will be an improving trend of responding to informal concerns within the Trust timescale of 5 days.

3.4 Actions and learning from informal PALS concerns

Themes and trends regarding informal PALS concerns are reviewed at the Divisional Integrated Governance meetings to ensure dissemination, learning and identification of local and strategic actions. Updates are shared by the Divisions at the Clinical Quality steering Group (CQSG) each month to ensure Trust wide learning.

4. Compliments in Q4

Compliments are an equally important measure of the quality of care, treatment and service the Trust delivers, providing powerful and valuable feedback and demonstrating that a family feels compelled to share this with us by taking precious time to share what has been good about their experience. This feedback also provides important balance with concerns raised.

There is currently limited information recorded in the central Ulysses system in regards to compliments although it must be noted that the Community Division continue to input a large number of compliments as shown in Table 6 below. It is acknowledged that the Trust receives many more compliments which have not been centrally recorded. Moving forward, the review of the complaints and PALS structure and roles will include capturing this important evidence of positive patient and family experiences.

Table 6: Compliments recorded on Ulysses	
Division	**No. of compliments**
Community	83
Medicine	2
Surgery	3

Appendix II provides examples of compliments received during Q4.

5. Proposed developments in the management of complaints and PALS

The Chief Nurse has commissioned the Director of Nursing to review the structure, responsibilities and process for management of complaints and PALS in the Trust to include a central corporate function which will sit within the Patient Experience team.

A comprehensive improvement plan has been devised and is being monitored through CQSG on a monthly basis. The improvement plan is also being monitored through the newly formed Patient Experience Group (PEG) on a monthly basis.

It is expected that implementation of the improvement plan will lead to a demonstrable improvement in compliance with KPI's, and more importantly a more timely and effective resolution for families who wish to raise concerns.

Improvements have already been made; whilst the Ulysses Complaints module is being updated, the complaint management process has moved to an electronic system. This has been evaluated positively by the Chief Nurse and the PALS and Complaints Officers. Work to improve the advice to parents on the Trust website has commenced with numbers no longer in use being decommissioned. Significant improvement has been seen in respect of the 3-day acknowledgment standard and the 25 day response.

6. Conclusion

The Board are asked to note the content of this report and support the proposed developments outlined in section 5 of this report.

Appendix I: Number of open and closed formal complaints by month 2019/20

Table 7 shows there were 115 formal complaints opened in 2019/20 and 117 closed.

Complaints that are received in a month may not be responded to until the next month in line with the 25 day response timeframe.

Table 7: Formal complaints received 2019/20													Cumulative to date
Month	**April**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	
New	8	9	6	14	12	11	5	16	8	10	9	7	**115**
Open	*22	18	14	22	24	25	21	26	25	25	29	25	
Closed	13	13	10	6	10	10	9	11	9	10	5	11	**117**

Note* 14 complaints carried over from the previous financial year 2018/19

Appendix II: Examples of compliments received during Q4

Multiple as listed: (logged as Medicine: Endocrine)

"Hi. My name is (parent), my little boy (child) has recently been discharged from yourselves. Firstly this is absolutely NOT a complaint, I wanted to pass on a big Thank you to all departments involved in my son's care. Over the last 18 months we have been under the care of Consultant Urologist Miss McAndrew awaiting our first procedure. In this time we have had multiple outpatient appointments, telephone consultations, surgery, admission and additional procedure. Despite the difficulties and pressures the NHS is currently faced with during the pandemic we wanted to pass on our gratitude for the fantastic care we have received from the following departments:

Miss McAndrew and her team.
Dianne (Urology secretary)
All of the Urology nurses
All of the endocrine nurses
Covid test centre
Covid screeners
Surgical admissions
All staff on 3A
Anaethetist Dr Livingstone
Day Surgery
Recovery
Theatre staff
All admin, domestics, porters

Please forward this email to the relevant department. We are truly grateful for the care, compassion, and empathy our special little boy has received. Thank you"

Psychology

"I just wanted to say thank you for all that you've done for us over the past three months. It has been great working with you. Even though we never met in person, your kind and calming style meant it felt like we were talking in the same room. You are a credit to Aldey Hey, the NHS, and your profession and I wish you every success in the future."

Orthopaedics

"Just wanted to pass on our sincere thanks to Mr Bruce and his secretary, Karen, for their utterly fantastic care and support over the past 8 years. My daughter is now moving on to Adult acute care and the entire family will always be grateful for everything Mr Bruce has done for her. I know I don't need to tell you this, but Mr Bruce is everything you would ever want in a consultant and should be held up as a role model for all others."

Craniofacial

"I want to send huge praise to Colette Turnock. I have been the worst example of a medical parent today having received a surgery date for my son. Colette has been so understanding answering my numerous emails and going above and beyond to put my mind at rest. Thank You so much."

North Sefton

"Thank you for all your hard work and input with (child). He always looked forward to our sessions. Hopefully we will be able to continue face to face in the near future. You've given us lots of great advice and ideas moving forward. Please could you pass on our thanks to Rachael too for her planning and input. We look forward to continue working with you soon. You have built such a nice strong rapport with (child) under difficult circumstances and in such a short amount of time. Many thanks!"

SALT digital therapy

"We are so grateful for all your help, can't thank you enough. (child) has grown so much in such a short space of time,.... also thank you for all the support you gave me too with the weekly phonecalls.'

Eating Disorder Service

"Emily we genuinely cannot thank you enough. for the outstanding professional support, care and advice you provided to both (child) and us as a family which enabled (child) to make a full recovery. We will never forget this - with sincere thanks and appreciation to you. Could you please also convey our special thanks and appreciation to Adele and all of the Team, you are all absolutely amazing."

Developmental Paediatrics

"Would like to say a big thank you to Darren Cannon admin staff for developmental paediatrics. Darren is a great help to all the staff in the team. He is always willing to help in any way he can. IT problems, sending documents out in the post, dealing with queries"

Children's Community Nursing

" thank you so much for the care you provided and sorting out all my queries regarding mine and (child's) bloods"

Community CAMHS

"I am writing this letter so I may share with you, the exceptional service that Claire Kitson is currently providing for my daughter. I feel that Claire shows professionalism in what she does, but also goes out of her way to check up on (child) and to keep me thinking positively.

It's been a very difficult time for us and I have felt that Claire always has our backs. I totally trust and follow her personal judgement on (child) well being, and most importantly, (child) does also.I am very grateful for the service that Claire provides us, having been allocated as my daughter's case worker."

NHS
Alder Hey Children's
NHS Foundation Trust
TRUST BOARD Report May 2021
BRILLIANT
BASICS
GROW THE
FUTURE

How Did We Do?

Executive Summary **Month: May** **Year: 2021**

Delivery of Outstanding Care

Safe

- Rates of incident reporting remain high with one severe harm incident reported in May. 72 hour review undertaken and Duty of Candour requirement met
- There continues to be low rates of pressure ulcers reported with 1 category 1 incident reported in May
- Ten-fold error Quality Summit held with 85 attendees from within the Trust and external partners. Nine workstreams identified as priority areas to reduce the risk of ten-fold error
- There has been a sustained improvement in the administration of IV antibiotics to patients with suspected sepsis in the ED department in month and 89.7% of patients within the in-patient setting receiving their treatment in 60 minutes, narrowly missing the target of 90%
- The range of IPC metrics continues to be positive. The satisfaction rate for inpatients remains high with a slight decline in all other areas. The Trust now benchmark against national average for response rates across this range of metrics where they exist and there is a need to improve in the number of responses across all areas

Highlight

- Continued excellence in relation to IPC and pressure ulcer metrics
- Sustained improvement in the administration of IV antibiotics for suspected sepsis in the emergency department

Challenges

- One reported case of C-difficile which is being investigated

The Best People Doing their Best Work

Caring

- Patient Experience Group (PEG) held second meeting; attended by range of Trust staff and Healthwatch. Meeting commenced with an impactful parent story
- Trust achieved 100% of formal complaints acknowledged within 3 working days in May
- Trust achieved 100% of formal complaint responses within 25 working days in May There has been a continuing trend of improvement in responding to PALS complaints within 5 days
- There has been a continuing trend of improvement in responding to PALS complaints within 5 days
- There continues to be strong satisfaction with the range of patient survey metrics except for satisfaction with play which continues to need attention

Highlight

- 100% of complaints responded to in 25 days, exceeding the Trust target

Challenges

- Improving trend for responding to PALS concerns but improvements needed to meet the target
- Continued focus on satisfaction with play services
- Response rate to FFT surveys need to increase to be in line with the national average

Delivery of Outstanding Care

Effective

The surge in urgent care demand has continued and grown exponentially with attendances in May 2021 at 134% of 2019 levels. This has led to an increase in the number of C&YP waiting over 4 hours for treatment, with performance reducing to 81.1%. There is an action plan in place internally and work with partners to improve access to urgent care in the community.

Highlight

- Low number of cancelled operations

Challenges

- Attendance levels and timeliness of care in ED
- Patients re-booked for treatment within 28 days following a cancelled operation

Delivery of Outstanding Care

Responsive

There has been a reduction in the number of children waiting over 52 weeks for treatment from 283 in April to 235 in May. This improvement has been driven by high levels of recovery in outpatients (113%) and elective care (107%).

Looking ahead, the number of patients waiting over 52 weeks may increase in June as we complete the safe waiting list data quality reviews. In Q2 this will be offset by the national accelerator programme delivering additional capacity through investment in equipment, staffing levels and additional sessions. We expect an additional 4,000 patients to receive treatment this year through this programme.

Highlight

- Recovery of services
- Reduction in the number of patients waiting 52 weeks for treatment
- Access to cancer care

Challenges

- Overall number of patients waiting 52 weeks for treatment

The Best People Doing their Best Work

Well Led

Finance

For the Month of May (Month 2), the Trust is reporting a deficit of £0.6m which is £0.4m adverse to plan.

This deficit is largely due to ongoing costs in relation to COVID and reduced car parking and catering income. There are also historical cost pressures within pay for the surgical division.

The trust is still awaiting the finalisation of the funding arrangements for additional activity and other COVID related pressures, and this should be addressed in due course.

Cash in the bank at the end of May was £88.4m.

The overall capital expenditure in month for May was £0.2m (£2.1m year to date) against a plan of £1.1m in month (£2.2m year to date) and this mainly relates to advance costs for the Community Cluster & Dewi Jones development.

The external audit for 2021/22 is now drawing to a close with accounts being presented to Audit & Risk Committee in June.

Sickness update

Sickness has risen this month by 0.5%, 0.2% due to long term sickness and 0.3% due to short term sickness. The HR team continue to work closely with managers and leaders across the Trust to provide advice and guidance and to ensure appropriate support is in place.

Mandatory Training

Overall Mandatory Training has remained at 88% for this month, but is still steadily returning back to the target of 90% based on recent trajectory. As per previous updates our key areas of focus are practical topics with frequent refreshers that require face to face training to take place and our Estates and Ancillary staff as a wider staff group.

We have seen some consistent steady improvements within Resus, now up to 74% overall but still a long way to go in both of the annual topics (Basic Life Support & PLS/APLS Annual Update) which are slowly improving.

We have seen some great progress within the Estates and Ancillary staff group, up to 67% overall compared to 52% at the start of April 2021.

Unfortunately the topic that is still struggling to show improvement is the annual Moving

Highlight

- Long term sickness rates falling
- Mandatory Training

Challenges

- Number of patients waiting over 52 weeks for treatment.
- Continue to work with NHSI re clarification of funding arrangements for 2021/22.
- Completion of the year end external audit.

and Handling Level 2 training which requires practical training, this topic is currently at 71% overall. The drop is believed to be in part due to the previous key moving and handling trainer leaving the Trust in the last couple of months. **PDR** With 2 months left of the appraisal window, we're starting to see people completing their staff appraisals and recording them into ESR with just over 6% of appraisals having been completed up until this point. We've now run 4 PDR Workshops for reviewers and have 4 scheduled to take place over the coming weeks to ensure that managers are best equipped to have meaningful appraisal conversations and are prepared for the new addition of the wellbeing conversation. Regular reporting and updates will start to be seen at Organisational level as we move through the window to ensure that the appraisal process and deadlines are promoted throughout the Trust.	

Game Changing Research and Innovation

Research and Development

Month 2 Research Activity:

- 139 research studies currently open
- 889 patients recruited to research studies (1935 in 21/22)

Divisional Participation:

- Division of Medicine – 115 open studies
- Division of Surgical Care – 22 open studies
- Division of Community & Mental Health – 2 open studies

Research Assurance:

- GCP training compliance – 97%
- Research SOP compliance – 98%

Highlight

- Recovery of research activity on track

Challenges

- Delays in staff recruitment

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Leading Metrics

SAFE

Metric	Value	Period
Clinical Incidents resulting in catastrophic, death	0	May 2021
Hospital Acquired Organisms - C.difficile	1	May 2021
Hospital Acquired Organisms - MRSA (BSI)	0	May 2021
Medication errors resulting in harm	3	May 2021
Never Events	0	May 2021
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients	89.66 %	May 2021
Sepsis: Patients treated for Sepsis within 60 Minutes - A&E	94.44 %	May 2021

CARING

Metric	Value	Period
Friends & Family: Overall Percentage Recommended Trust	90.20 %	May 2021

EFFECTIVE

Metric	Value	Period
ED: 95% Treated within 4 Hours	81.10 %	May 2021

RESPONSIVE

Metric	Value	Period
31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)	100 %	May 2021
All Cancers: 31 day wait until subsequent treatments	100 %	May 2021
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	100 %	May 2021
Diagnostics: % Completed Within 6 Weeks	95.24 %	May 2021
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	100 %	May 2021
RTT: Open Pathway: % Waiting within 18 Weeks	71.88 %	May 2021
Waiting Greater than 52 weeks - Incomplete Pathways	235	May 2021
Waiting List Size	11565	May 2021

WELL LED

Metric	Value	Period
Cash in Bank (£'000s)	88440	May 2021
Control Total In Month Variance (£'000s)	589.72	May 2021
Mandatory Training	87.21 %	May 2021
Safer Staffing (Shift Fill Rate)	98.78 %	May 2021
Sickness	5.13 %	May 2021

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Delivery of Outstanding Care

SAFE

D Drive W Watch P Programme

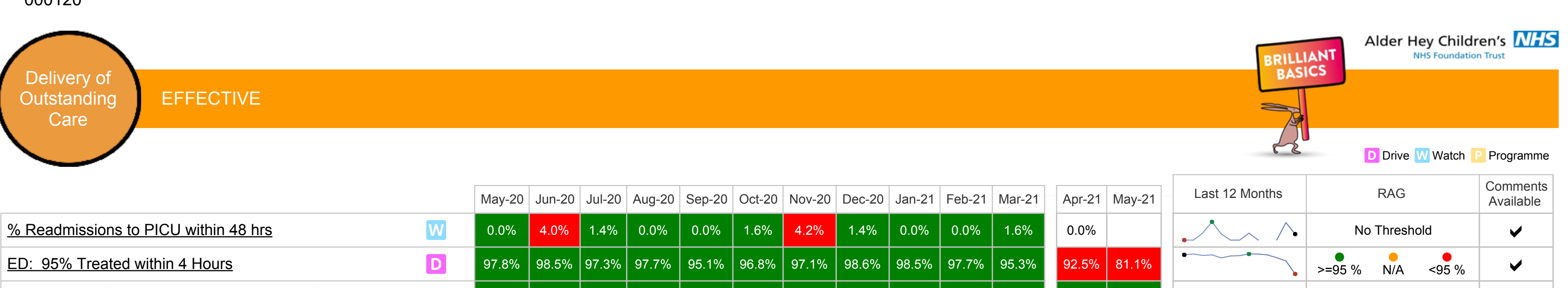
Indicator	Type	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Last 12 Months	RAG			Comments Available
Proportion of Near Miss, No Harm & Minor Harm	D	100.0%	100.0%	98.9%	99.1%	100.0%	100.0%	100.0%	99.8%	99.8%	99.8%	99.8%	99.8%	99.1%		>=99 %	N/A	<99 %	✔
Clinical Incidents resulting in Near Miss	D	48	59	85	52	50	75	100	75	53	65	97	80	83		No Threshold			
Clinical Incidents resulting in No Harm	D	261	286	382	323	341	329	410	313	287	332	401	394	359		No Threshold			
Clinical Incidents resulting in minor, non permanent harm	D	57	88	91	83	70	66	83	75	81	76	96	91	82		No Threshold			
Clinical Incidents resulting in moderate, semi permanent harm	D	0	0	6	1	0	0	0	1	1	1	1	1	4		No Threshold			
Clinical Incidents resulting in severe, permanent harm	D	0	0	0	2	0	0	0	0	1	0	0	0	1		0	N/A	>0	✔
Clinical Incidents resulting in catastrophic, death	D	0	0	0	0	0	0	0	0	1	0	0	0	0		0	N/A	>0	✔
Medication errors resulting in harm	D	5	7	6	2	8	1	11	0	6	3	4	4	3		<=4	N/A	>4	✔
Pressure Ulcers (Category 3)	W	0	0	2	0	0	0	0	1	0	0	0	0	0		0	N/A	>0	✔
Pressure Ulcers (Category 4)	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
Never Events	W	0	0	0	0	0	0	0	0	0	0	1	0	0		0	N/A	>0	✔
Sepsis: Patients treated for Sepsis within 60 Minutes - A&E	D P	95.5%	96.2%	79.2%	77.3%	85.2%	74.1%	79.2%	73.7%	89.5%	80.6%	100.0%	85.0%	94.4%		>=90 %	N/A	<90 %	✔
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients	D P	87.5%	90.9%	88.5%	85.2%	86.1%	94.3%	80.8%	70.8%	87.5%	84.0%	88.9%	83.3%	89.7%		>=90 %	N/A	<90 %	✔
Number of children that have experienced avoidable factors causing death - Internal	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
Hospital Acquired Organisms - MRSA (BSI)	D	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
Hospital Acquired Organisms - C.difficile	D	0	0	0	0	1	1	0	0	0	0	0	0	1		0	N/A	>0	✔
Hospital Acquired Organisms - MSSA	D	0	0	1	4	1	0	1	0	3	1	0	0	1		No Threshold			

The Best People doing their best Work

CARING

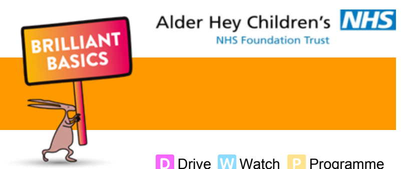
D Drive W Watch P Programme

Measure	Type	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Last 12 Months	RAG	Comments Available
Friends & Family: Overall Percentage Recommended Trust	W	94.2%	94.9%	94.6%	93.8%	90.6%	94.7%	93.7%	91.5%	95.3%	94.9%	92.9%	94.0%	90.2%		>=95 % >=90 % <90 %	✔
Friends & Family A&E - % Recommend the Trust	D	92.9%	92.3%	90.7%	91.5%	84.4%	92.1%	89.2%	91.5%	93.2%	93.1%	88.0%	88.0%	76.2%		>=95 % >=90 % <90 %	✔
Friends & Family Community - % Recommend the Trust	D	100.0%	95.2%	95.2%	92.3%	89.1%	94.7%	98.8%	100.0%	92.7%	96.7%	93.0%	95.9%	92.4%		>=95 % >=90 % <90 %	✔
Friends & Family Inpatients - % Recommend the Trust	D	90.8%	93.3%	97.0%	95.1%	92.4%	94.5%	95.5%	93.4%	94.2%	90.4%	89.8%	96.4%	95.1%		>=95 % >=90 % <90 %	✔
Friends & Family Mental Health - % Recommend the Trust	D	90.9%	100.0%	100.0%	82.4%	92.3%	89.7%	91.3%	100.0%	96.3%	90.3%	87.9%	90.6%	85.7%		>=95 % >=90 % <90 %	✔
Friends & Family Outpatients - % Recommend the Trust	D P	96.9%	96.6%	96.0%	95.7%	94.1%	95.5%	93.9%	90.4%	96.1%	96.0%	95.1%	95.3%	94.4%		>=95 % >=90 % <90 %	✔
Complaints	W	6	10	5	20	11	19	15	10	15	11	23	7	9		No Threshold	
PALS	W	44	86	105	105	77	96	72	65	67	88	110	100	118		No Threshold	



		May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Last 12 Months	RAG			Comments Available
% Readmissions to PICU within 48 hrs	W	0.0%	4.0%	1.4%	0.0%	0.0%	1.6%	4.2%	1.4%	0.0%	0.0%	1.6%	0.0%			No Threshold			✔
ED: 95% Treated within 4 Hours	D	97.8%	98.5%	97.3%	97.7%	95.1%	96.8%	97.1%	98.6%	98.5%	97.7%	95.3%	92.5%	81.1%		>=95 %	N/A	<95 %	✔
ED: Number of patients spending >12 hours from decision to admit to admission	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
On the day Elective Cancelled Operations for Non Clinical Reasons	D	5	3	7	18	17	19	16	10	5	7	12	13	7		<=20	N/A	>20	✔
28 Day Breaches	W	1	2	0	0	8	2	1	3	3	1	2	4	3		0	N/A	>0	✔

RESPONSIVE



D Drive W Watch P Programme

Measure	Type	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Last 12 Months	RAG (Green)	RAG (Amber)	RAG (Red)	Comments Available
IP Survey: % Received information enabling choices about their care	W	93.2%	94.1%	99.3%	95.9%	95.4%	95.4%	95.7%	97.5%	99.3%	93.6%	95.6%	96.0%	98.0%		>=95 %	>=90 %	<90 %	✔
IP Survey: % Treated with respect	W	97.7%	94.1%	98.5%	97.9%	96.0%	98.3%	98.6%	97.5%	100.0%	98.1%	94.7%	98.5%	99.0%		>=95 %	>=90 %	<90 %	✔
IP Survey: % Know their planned date of discharge	D P	95.5%	95.8%	98.5%	93.2%	97.1%	96.7%	97.8%	95.0%	98.5%	98.1%	94.2%	98.5%	92.2%		>=90 %	>=85 %	<85 %	✔
IP Survey: % Know who is in charge of their care	W	90.9%	90.8%	91.1%	99.3%	98.3%	100.0%	99.3%	91.7%	100.0%	94.9%	96.1%	98.5%	98.5%		>=95 %	>=90 %	<90 %	✔
IP Survey: % Patients involved in Play	D	78.4%	64.7%	72.6%	81.5%	82.3%	83.3%	84.9%	76.7%	80.3%	85.9%	78.2%	81.1%	80.0%		>=90 %	>=85 %	<85 %	✔
IP Survey: % Patients involved in Learning	D	61.4%	84.0%	83.0%	78.1%	75.4%	88.3%	71.9%	81.6%	94.9%	92.9%	90.9%	91.0%	91.7%		>=90 %	>=85 %	<85 %	✔
RTT: Open Pathway: % Waiting within 18 Weeks	W	58.1%	45.9%	39.6%	43.1%	48.2%	54.2%	59.0%	60.8%	61.3%	63.4%	68.3%	68.6%	71.9%		>=92 %	>=90 %	<90 %	✔
Waiting List Size	W	10,909	11,248	11,022	11,402	11,000	10,939	10,832	10,520	10,722	11,535	11,979	11,111	11,565		No Threshold			
Waiting Greater than 52 weeks - Incomplete Pathways	W	52	82	149	127	145	145	148	184	222	307	361	283	235		0	N/A	>0	✔
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	W	100.0%	100.0%	95.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 %	N/A	<100 %	✔
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 %	N/A	<100 %	✔
All Cancers: 31 day wait until subsequent treatments	W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 %	N/A	<100 %	✔
31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)	W	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 %	N/A	<100 %	✔
Diagnostics: % Completed Within 6 Weeks	W	67.0%	81.9%	82.9%	78.9%	91.8%	96.4%	97.1%	92.3%	93.7%	95.8%	97.5%	95.2%	95.2%		>=99 %	N/A	<99 %	✔
PFI: PPM%		100.0%	100.0%	100.0%	99.0%	99.0%	100.0%	98.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%		>=98 %	N/A	<98 %	✔

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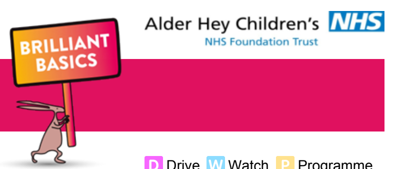
WELL LED

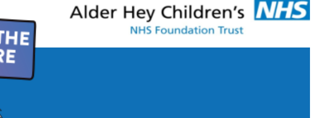


D Drive W Watch P Programme

Measure	Type	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Last 12 Months	RAG	Comments Available
Control Total In Month Variance (£'000s)	W	-1	0	-1	-1	-1	-359	331	686	242	590	3,824	-955	592		>=-5% >=-20% <-20%	✔
Capital Expenditure In Month Variance (£'000s)	W	1,792	3,503	936	-483	4,518	187	-1,733	1,610	-1,979	-3,207	-5,794	-910	974		>=-5% >=-10% <-10%	✔
Cash in Bank (£'000s)	W	111,270	107,221	107,221	107,763	108,756	109,084	110,503	110,776	110,776	110,871	92,708	92,708	88,440		>=-5% >=-20% <-20%	✔
Income In Month Variance (£'000s)	W	-693	1,341	1,825	1,076	2,492	-793	748	234	227	2,309	18,172	-493	715		>=-5% >=-20% <-20%	✔
Pay In Month Variance (£'000s)	W	691	-312	-340	-291	-1,160	20	492	-192	-373	-387	-13,171	-308	-370		>=-5% >=-20% <-20%	✔
Non Pay In Month Variance (£'000s)	W	1	-1,029	-1,485	-786	-1,333	414	-909	644	387	-1,333	-1,176	-154	247		>=-5% >=-20% <-20%	✔
AvP: IP - Non-Elective	W	0	0	0	0	-349	-398	-456	-402	-499	-450	112	1,198	1,260		>=0 N/A <0	✔
AvP: IP Elective vs Plan	W	0	-1	0	-1	49	9	11	52	-44	-14	169	411	434		>=0 N/A <0	✔
AvP: Daycase Activity vs Plan	W	3	5	3	2	-62	-183	43	69	-340	-137	673	1,911	1,793		>=0 N/A <0	✔
AvP: Outpatient Activity vs Plan	W	344	1,105	1,465	1,468	1,230	-1,079	2,336	2,637	-1,062	1,712	8,938	24,442	24,187		>=0 N/A <0	✔
PDR	W	1.3%	5.4%	13.4%	20.7%	29.5%	62.6%	72.4%	74.6%	74.4%	74.4%	74.4%	0.9%	6.3%		No Threshold	✔
Medical Appraisal	W	95.6%	95.6%	95.6%	95.6%	95.6%	95.6%	95.6%	95.9%	95.9%	95.9%	95.9%	21.9%	30.9%		No Threshold	✔
Mandatory Training	W	90.8%	91.0%	90.5%	90.6%	89.3%	88.6%	85.8%	85.0%	86.0%	85.8%	86.8%	88.4%	87.2%		>=90 % >=80 % <80 %	✔
Sickness	D	5.2%	5.0%	5.1%	5.0%	5.2%	6.0%	5.4%	5.6%	7.2%	5.7%	4.7%	4.5%	5.1%		<=4 % <=4.5 % >4.5 %	✔
Short Term Sickness	D	1.0%	0.9%	1.0%	1.1%	1.4%	1.9%	1.3%	1.1%	2.3%	1.2%	1.2%	1.1%	1.4%		<=1 % N/A >1 %	✔
Long Term Sickness	D	4.2%	4.0%	4.1%	3.9%	3.9%	4.1%	4.2%	4.5%	4.9%	4.5%	3.6%	3.4%	3.8%		<=3 % N/A >3 %	✔
Temporary Spend ('000s)	D	743	564	934	946	1,015	1,062	1,365	1,404	1,378	1,279	2,272	1,073	1,044		No Threshold	✔
Staff Turnover	D	9.8%	10.0%	9.6%	10.1%	9.8%	9.5%	9.3%	9.2%	9.2%	9.1%	9.1%	9.9%	10.8%		<=10 % <=11 % >11 %	✔
Safer Staffing (Shift Fill Rate)	W		95.6%	90.3%	91.3%	94.2%	94.2%	94.9%	93.6%	90.5%	94.5%	94.0%	97.7%	98.8%		>=90 % N/A <90 %	✔
Domestic Cleaning Audit Compliance	W		100.0%	85.6%	97.0%	93.8%	90.0%	87.5%	90.4%	94.4%	97.7%	97.7%	97.7%			>=85 % N/A <85 %	✔
NHS Oversight Framework	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 <=1 >1	✔

000123

R&D



D Drive W Watch P Programme

Measure	Type	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Last 12 Months	RAG (Green)	RAG (Amber)	RAG (Red)	Comments Available
Number of Open Studies - Academic	W	23	43	47	50	61	66	71	76	80	80	90	100	103		>=130	>=111	<111	✔
Number of Open Studies - Commercial	W	19	20	25	27	28	34	37	36	36	36	36	34	36		>=30	>=21	<21	✔
Number of New Studies Opened - Academic	W	3	3	1	3	4	1	4	4	1	0	6	7	2		>=3	>=2	<2	✔
Number of New Studies Opened - Commercial	W	0	0	1	2	0	2	1	0	0	0	2	0	3		>=1	N/A	<1	✔
Number of patients recruited	W	537	560	134	508	413	665	832	182	504	403	105	1,046	889		>=100	>=86	<86	✔

Delivery of Outstanding Care

7.1 - QUALITY - SAFE

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Proprtion of Incidents	**Proportion of Near Miss, No Harm & Minor Harm** D Proportion of Near Miss, No Harm and Minor Harm incidents against all levels recorded. **Exec Lead:** Nicki Murdock **Committee:** SQAC	99.05 %	R <99 % A N/A G >=99 %		No Action Required
Incidents: Increasing Reporting	**Clinical Incidents resulting in Near Miss** D Total number of Near Miss Incidents reported **Exec Lead:** Nicki Murdock **Committee:** SQAC	83	No Threshold		
Incidents: Increasing Reporting	**Clinical Incidents resulting in No Harm** D Total number of No Harm Incidents reported. **Exec Lead:** Nicki Murdock **Committee:** SQAC	359	No Threshold		

Delivery of Outstanding Care

7.2 - QUALITY - SAFE

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Incidents: Reducing Harm	**Clinical Incidents resulting in minor, non permanent harm** D Total number of Minor Harm Incidents reported. **Exec Lead:** Nicki Murdock **Committee:** SQAC	82	No Threshold		
Incidents: Reducing Harm	**Clinical Incidents resulting in moderate, semi permanent harm** D Incidents reported resulting in moderate harm. **Exec Lead:** Nicki Murdock **Committee:** SQAC	4	No Threshold		
Incidents: Reducing Harm	**Clinical Incidents resulting in severe, permanent harm** D Incidents reported resulting in severe harm. The threshold is based on this event never occuring. 21/22 aim is zero annually. **Exec Lead:** Nicki Murdock **Committee:** SQAC	1	R >0 A N/A G 0		Management of deteriorating patient: Patient History: Multiple cardiac co-morbidities, cardiac arrest on ward, patient transferred to PICU, died on 14TH May 2021.. Incident reported to StEIS, duty of candour completed in line with regulation 20, 72 hour review completed, RCA 2 in progress.

Delivery of Outstanding Care

7.3 - QUALITY - SAFE

D Drive W Watch P Programme

	Description	Performance	Threshold		Trend	Management Action (SMART)
Incidents: Reducing Harm	**Clinical Incidents resulting in catastrophic, death** D Incidents reported resulting in severe harm. The threshold is based on this event never occuring. 21/22 aim is zero annually. **Exec Lead:** Nicki Murdock **Committee:** SQAC	0	R A G	>0 N/A 0		No Action Required
Reducing Medication Errors	**Medication errors resulting in harm** D Medication errors reported resulting in minor, moderate, major or catastrpohic (death) harm. The threshold is based on achieving a 20% reduction on the period Apr 20 - Mar 21. 21/22 aim is less than 52 annually for the trust. **Exec Lead:** Nicki Murdock **Committee:** SQAC	3	R A G	>4 N/A <=4		No Action Required
Reducing Pressure Ulcers	**Pressure Ulcers (Category 3)** W Pressure Ulcers of Category 3. The threshold is based on this event never occuring. 21/22 Aim is zero annually. **Exec Lead:** Nicki Murdock **Committee:** SQAC	0	R A G	>0 N/A 0		No Action Required

Delivery of Outstanding Care

7.4 - QUALITY - SAFE

D Drive W Watch P Programme

	Description	Performance	Threshold		Trend	Management Action (SMART)
Reducing Pressure Ulcers	**Pressure Ulcers (Category 4)** W Pressure Ulcers of Category 4. The threshold is based on this event never occuring. 21/22 Aim is zero annually. **Exec Lead:** Nicki Murdock **Committee:** SQAC	0	R A G	>0 N/A 0		No Action Required
Never Events	**Never Events** W Never Events. The threshold is based on this event never occuring. 21/22 aim is zero annually. **Exec Lead:** Nicki Murdock **Committee:** SQAC	0	R A G	>0 N/A 0		No Action Required
Sepsis	**Sepsis: Patients treated for Sepsis within 60 Minutes - A&E** D P Percentage of Sepis Patients receiving antibiotic within 60 mins for ED. 21/22 aim is 90%. **Exec Lead:** Nicki Murdock **Committee:** SQAC	94.44 %	R A G	<90 % N/A >=90 %		No Action Required

Delivery of Outstanding Care

7.5 - QUALITY - SAFE

D Drive W Watch P Programme

	Description	Performance	Threshold		Trend	Management Action (SMART)
Sepsis	**Sepsis: Patients treated for Sepsis within 60 mins - Inpatients** D P Percentage of Sepis Patients receiving antibiotic within 60 mins for Inpatients. 21/22 aim is 90%. **Exec Lead:** Nicki Murdock **Committee:** SQAC	89.66 %	R A G	<90 % N/A >=90 %		Improvement in performance noted, increase in patient acuity in areas across the trust. Three delays two patients had IV Access difficulties, escalated for senior support no further clinical deterioration. One delay infant who required LP prior to starting IVAB as best practice. Evidence of alerting and escalating concerns, no note a high number of Oncology patients identified with clear escalation, management and electronic documentation completed. To continue providing feedback to teams and work on lessons to improve practice.
Mortality	**Number of children that have experienced avoidable factors causing death - Internal** W Total number of children that have experienced avoidable factors with issues relating to care provided in Alderhey. Figures provided by HMRG group. The threshold for 21/22 is zero. **Exec Lead:** Nicki Murdock **Committee:** SQAC	0	R A G	>0 N/A 0		No Action Required
Reducing Infections	**Hospital Acquired Organisms - MRSA (BSI)** D The threshold is based on this event never occuring. 21/22 Aim is zero annually. **Exec Lead:** Nicki Murdock **Committee:** SQAC	0	R A G	>0 N/A 0		No Action Required

Trend charts (May-20 to May-21); legend: Actual, Average, UCL, LCL, UWL, LWL, Green.

7.6 - QUALITY - SAFE

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Reducing Infections	**Hospital Acquired Organisms - C.difficile** D The threshold is based on this event never occuring. 21/22 Aim is zero annually. **Exec Lead:** Nicki Murdock **Committee:** SQAC	1	R >0 A N/A G 0	May-20 to May-21 chart (Actual, Average, UCL, LCL, UWL, LWL, Green)	
Reducing Infections	**Hospital Acquired Organisms - MSSA** D Hospital Acquired Organisms - MSSA . 20/21 aim is to reduce by 10% or more. **Exec Lead:** Nicki Murdock **Committee:** SQAC	1	No Threshold	May-20 to May-21 chart (Actual, Average, UCL, LCL, UWL, LWL, Green)	

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The Best People doing their best Work

8.1 - QUALITY - CARING

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Friends & Family	**Friends & Family: Overall Percentage Recommended Trust** W Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Nicki Murdock **Committee:** SQAC	90.20 %	R <90 % A >=90 % G >=95 %		Overall percentage has decreased from 93.95% to 90.20% from April 2021 to May 2021. There were 1,846 responses for May 2021. Medicine had a total of 891 responses with 93 negatives (9.31%), Surgery had a total of 664 responses with 27 negatives (4.07%), and Community had a total of 265 responses with 15 negatives (5.66%).
Friends & Family	**Friends & Family A&E - % Recommend the Trust** D Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Nicki Murdock **Committee:** SQAC	76.17 %	R <90 % A >=90 % G >=95 %		Overall percentage has significantly decreased by 11.8% from April 2021. There were 407 responses for May 2021, with 71 (17.45%) either poor or very poor. There were high number of attendances in May which impacted on patient experience due to long waits. When respondents were asked how we could have improved, 103 out of 317 comments (32.5%) mentioned waiting times as a major issue; 23 (7%) mentioned the attitude of triage staff; 14 responses (4.4%) mentioned communication between parents and staff; and 22 (6.9%) responses mentioned concerns regarding the COVID-19 safety of the waiting room.
Friends & Family	**Friends & Family Community - % Recommend the Trust** D Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Nicki Murdock **Committee:** SQAC	92.36 %	R <90 % A >=90 % G >=95 %		Overall percentage has decreased by 3.5% since April 2021. There were 265 responses for May 2021, 15 more than the previous month and the highest volume of responses in the past 12 months. There were 16 (6.67%) responses that were either poor or very poor in May 2021. Through comment analysis, there were no clear themes or trends identified when respondents were asked 'How could we improve?'. Out of the 16 poor or very poor responses, four responses came via the Blood Test Clinic, four came via ADHD service, and two came via Sefton CAMHS.

The Best People doing their best Work

8.2 - QUALITY - CARING

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Friends & Family	**Friends & Family Inpatients - % Recommend the Trust** D Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Nicki Murdock **Committee:** SQAC	95.10 %	R <90 % A >=90 % G >=95 %	Chart: May-20 to May-21 (Actual, Average, UCL, LCL, UWL, LWL, Green)	No Action Required
Friends & Family	**Friends & Family Mental Health - % Recommend the Trust** D Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Nicki Murdock **Committee:** SQAC	85.71 %	R <90 % A >=90 % G >=95 %	Chart: May-20 to May-21 (Actual, Average, UCL, LCL, UWL, LWL, Green)	Overall percentage has decreased by 4.9% since April 2021 to 85.71%. Lack of responses in this area (21) heavily impacts the overall percentage. For example, the 3 poor or very poor responses accounted for 14.28% of the overall percentage. Discussions surrounding improving response rates in this area have taken place to improve the quality of data. Comment analysis from all responses in May 2021 does not identify any recurring themes.
Friends & Family	**Friends & Family Outpatients - % Recommend the Trust** D P Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Nicki Murdock **Committee:** SQAC	94.43 %	R <90 % A >=90 % G >=95 %	Chart: May-20 to May-21 (Actual, Average, UCL, LCL, UWL, LWL, Green)	The percentage has increased by 0.9% since April 2021 to 94.4%. There were 1060 completed surveys, with 42 poor or very poor responses in this area. These poor or very poor responses account for 3.96% of overall percentage. Waiting time was highlighted as a major issue this month with the percentage decreasing from 75% to 68% in this question. When asked if we have put their child first, only 89% of respondents thought this to be the case which is the lowest percentage in the past 12 months.

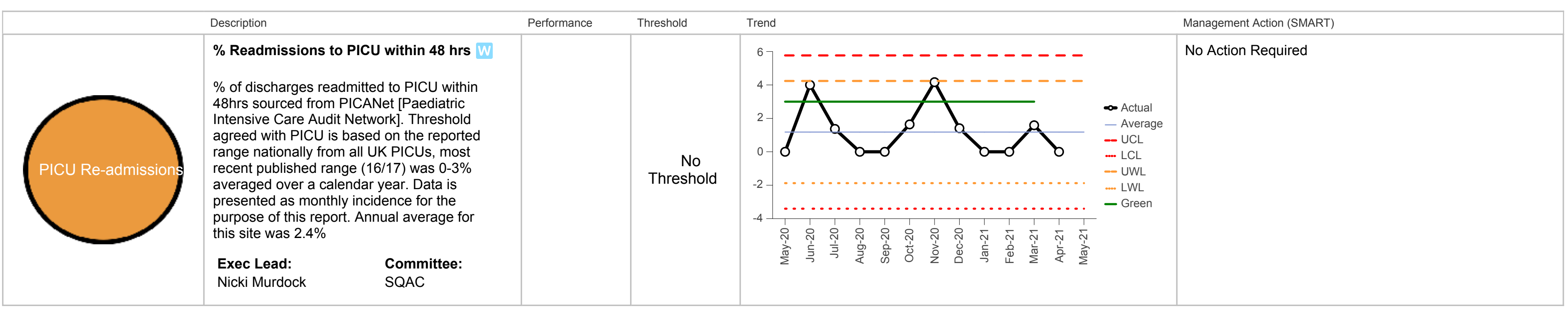
8.3 - QUALITY - CARING

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Complaints	**Complaints** W Total complaints received. **Exec Lead:** Nicki Murdock **Committee:** SQAC	9	No Threshold	Chart: Actual, Average, UCL, LCL, UWL, LWL, Green (May-20 to May-21)	
PALS	**PALS** W Total number of PALS contacts. **Exec Lead:** Nicki Murdock **Committee:** SQAC	118	No Threshold	Chart: Actual, Average, UCL, LCL, UWL, LWL, Green (May-20 to May-21)	

9.1 - QUALITY - EFFECTIVE

D Drive W Watch P Programme



	Description	Performance	Threshold	Trend	Management Action (SMART)
PICU Re-admissions	**% Readmissions to PICU within 48 hrs** W % of discharges readmitted to PICU within 48hrs sourced from PICANet [Paediatric Intensive Care Audit Network]. Threshold agreed with PICU is based on the reported range nationally from all UK PICUs, most recent published range (16/17) was 0-3% averaged over a calendar year. Data is presented as monthly incidence for the purpose of this report. Annual average for this site was 2.4% **Exec Lead:** Nicki Murdock **Committee:** SQAC		No Threshold		No Action Required

Delivery of Outstanding Care

10.1 - QUALITY - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

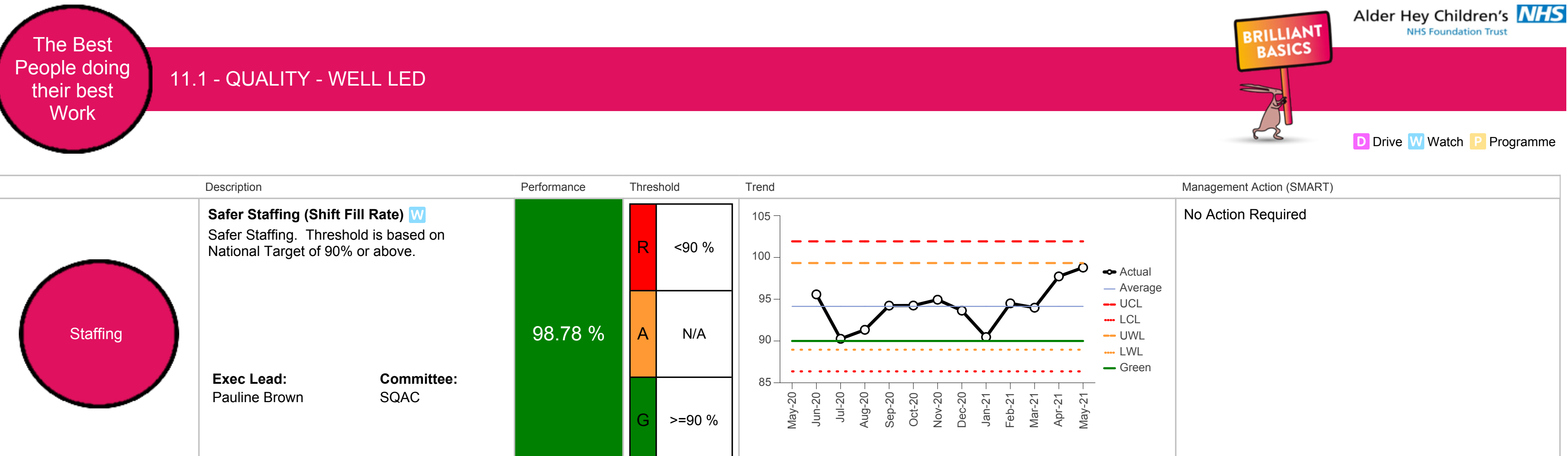
	Description	Performance	Threshold	Trend	Management Action (SMART)
Inpatient Survey: Choices	**IP Survey: % Received information enabling choices about their care** W Percentage of patients / families that report receiving information to enable them to make choices. Thresholds are based on previously defined local targets. The 21/22 aim is 95% or above. **Exec Lead:** Nicki Murdock **Committee:** SQAC	98.05 %	R <90 % A >=90 % G >=95 %	Chart (90–102; May-20 to May-21): Actual, Average, UCL, LCL, UWL, LWL, Green	No Action Required
Inpatient Survey: Respect	**IP Survey: % Treated with respect** W Percentage of children / families that report being treated with respect. Thresholds are based on previously defined local targets. The 21/22 is 100%. **Exec Lead:** Nicki Murdock **Committee:** SQAC	99.02 %	R <90 % A >=90 % G >=95 %	Chart (92–104; May-20 to May-21): Actual, Average, UCL, LCL, UWL, LWL, Green	No Action Required
Inpatient Survey: Date of Discharge	**IP Survey: % Know their planned date of discharge** D P Percentage of children / families that report knowing their planned date of discharge. Thresholds are based on previously defined local targets. The 21/22 aim is 90% or above. **Exec Lead:** Nicki Murdock **Committee:** SQAC	92.20 %	R <85 % A >=85 % G >=90 %	Chart (85–105; May-20 to May-21): Actual, Average, UCL, LCL, UWL, LWL, Green	No Action Required

Delivery of Outstanding Care

10.2 - QUALITY - RESPONSIVE

D Drive W Watch P Programme

	Description	Performance	Threshold		Trend	Management Action (SMART)
Inpatient Survey: In Charge of Care	**IP Survey: % Know who is in charge of their care** W % of children / families that report knowing who is in charge of their care. Thresholds are based on previously defined local targets. The 21/22 aim is 95% or above. **Exec Lead:** Nicki Murdock **Committee:** SQAC	98.54 %	R	<90 %		No Action Required
			A	>=90 %		
			G	>=95 %		
Inpatient Survey: Play	**IP Survey: % Patients involved in Play** D % of children / families that report engaging in play. Thresholds are based on previously defined local targets. The 21/22 aim is 90% or above. **Exec Lead:** Nicki Murdock **Committee:** SQAC	80 %	R	<85 %		The percentage of patients that reported engagement with play this month was 85.90%, a decrease of 1.1% from April 2021. There were 205 responses during May 2021. 41 of those responses said that they did not have access to play/activities. Of the 41 responses, 37% (15) came via Surgical Daycare, 20% (8) came via Ward 4A, and 10% (4) came from Ward 3A. Actions are taking place to improve Play performance with discussions regarding additional volunteer support and the recruitment of Play support currently ongoing.
			A	>=85 %		
			G	>=90 %		
Inpatient Survey: Learning	**IP Survey: % Patients involved in Learning** D % of children / families that report engaging in learning. Thresholds are based on previously defined local targets. The 21/22 aim is 90% or above. **Exec Lead:** Nicki Murdock **Committee:** SQAC	91.71 %	R	<85 %		No Action Required
			A	>=85 %		
			G	>=90 %		



The Best People doing their best Work
11.1 - QUALITY - WELL LED
BRILLIANT BASICS
Alder Hey Children's NHS
NHS Foundation Trust
D Drive W Watch P Programme
Description
Performance
Threshold
Trend
Management Action (SMART)
Staffing
Safer Staffing (Shift Fill Rate) W
Safer Staffing. Threshold is based on National Target of 90% or above.
Exec Lead:
Pauline Brown
Committee:
SQAC
98.78 %
R <90 %
A N/A
G >=90 %
105
100
95
90
85
May-20
Jun-20
Jul-20
Aug-20
Sep-20
Oct-20
Nov-20
Dec-20
Jan-21
Feb-21
Mar-21
Apr-21
May-21
Actual
Average
UCL
LCL
UWL
LWL
Green
No Action Required

Delivery of Outstanding Care

12.1 - PERFORMANCE - EFFECTIVE

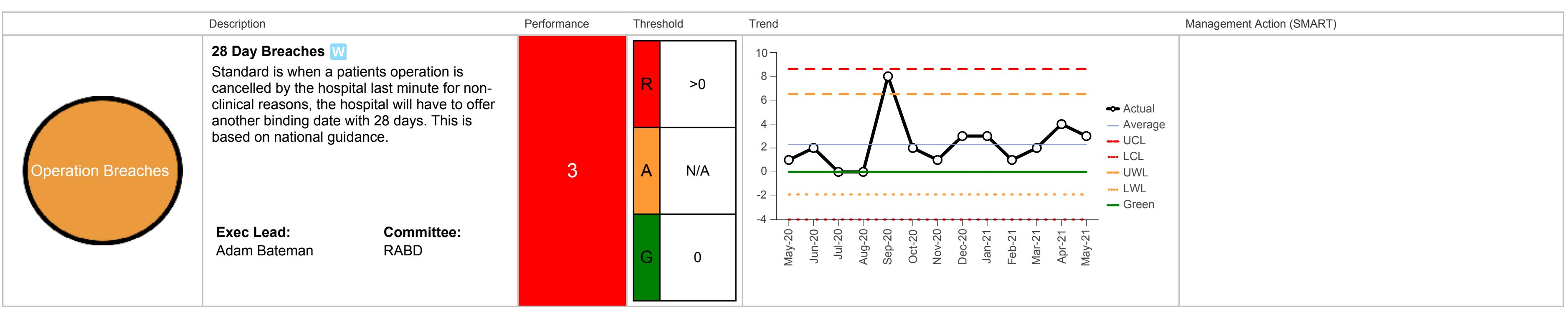
D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
ED 4 Hour Standard	**ED: 95% Treated within 4 Hours** D Threshold is based on National Guidance set by NHS England at 95%. **Exec Lead:** Adam Bateman **Committee:** RABD	81.10 %	R: <95 % A: N/A G: >=95 %		There is a significantly higher amount of attendances than usual for this time of year placing huge pressure on the dept. Attributing this to easing of lockdown restrictions, limited patient access to P/C, other healthcare providers and a lack of F2F appts. We are placing high priority on ensuring the dept is well staffed and staff's well-being. High-med acuity patients continue to be priority, however we are looking at deflection of certain patients were appropriate to access providers/treatments most suitable. Comms about ED have also been stepped up with the aim relieve pressure within ED.
ED 12 Hr Waits	**ED: Number of patients spending >12 hours from decision to admit to admission** W Number of patients spending >12 hours in A&E from decision to admit to admission. This is a national standard with a zero tolerance threshold. **Exec Lead:** Adam Bateman **Committee:** RABD	0	R: >0 A: N/A G: 0		No Action Required
Cancelled Operations	**On the day Elective Cancelled Operations for Non Clinical Reasons** D Performance is measured for on the day cancelled elective operations for non clinical reasons. This based on National Guidance. **Exec Lead:** Adam Bateman **Committee:** RABD	7	R: >20 A: N/A G: <=20		No Action Required

Trend chart legend: Actual, Average, UCL, LCL, UWL, LWL, Green. X-axis: May-20, Jun-20, Jul-20, Aug-20, Sep-20, Oct-20, Nov-20, Dec-20, Jan-21, Feb-21, Mar-21, Apr-21, May-21.

12.2 - PERFORMANCE - EFFECTIVE

D Drive W Watch P Programme



	Description	Performance	Threshold		Trend	Management Action (SMART)
Operation Breaches	**28 Day Breaches** W Standard is when a patients operation is cancelled by the hospital last minute for non-clinical reasons, the hospital will have to offer another binding date with 28 days. This is based on national guidance. **Exec Lead:** Adam Bateman **Committee:** RABD	3	R	>0		
			A	N/A		
			G	0		

Delivery of Outstanding Care

13.1 - PERFORMANCE - RESPONSIVE

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
RTT	**RTT: Open Pathway: % Waiting within 18 Weeks** W Percentage of patients waiting within 18 weeks. Threshold is based on previous national target of 92%, this is applied in order to maintain monitoring of measure. **Exec Lead:** Adam Bateman **Committee:** RABD	71.88 %	R <90 % A >=90 % G >=92 %	Chart (May-20 to May-21): Actual, Average, UCL, LCL, UWL, LWL, Green	Performance continues to improve with notable progress against our restoration targets. Continued challenges remain primarily within surgical specialities however the most challenges specialities have made significant progress over recent weeks. Each speciality below 95% RTT has an individual delivery plan to support there achievement of RTT pathways within coming weeks or months.
Waiting Times	**Waiting List Size** W Total waiting list size of Inpatient and Outpatient RTT incomplete pathways **Exec Lead:** Adam Bateman **Committee:** RABD	11565	No Threshold	Chart (May-20 to May-21): Actual, Average, UCL, LCL, UWL, LWL, Green	
Waiting Times	**Waiting Greater than 52 weeks - Incomplete Pathways** W Total number of more than 52 weeks for first treatment on an incomplete pathway. The threshold is based on this event never occuring. 21/22 aim is zero annually. **Exec Lead:** Adam Bateman **Committee:** RABD	235	R >0 A N/A G 0	Chart (May-20 to May-21): Actual, Average, UCL, LCL, UWL, LWL, Green	Second consecutive month there has been a reduction in the number of C&YP waiting over 52wks to receive treatment. Majority of patients are waiting surgical treatment. All have received a clinical review with plans to treat asap. Challenging specialities have made significant progress by creating more capacity to accommodate as many of these C&YP. Some of the C&YP have also been established via additional validation associated with the Safe WL Programme.

Delivery of Outstanding Care

13.2 - PERFORMANCE - RESPONSIVE

D Drive W Watch P Programme

	Description	Performance	Threshold		Trend	Management Action (SMART)
Cancer RTT	**Cancer: 2 week wait from referral to date 1st seen - all urgent referrals** W Threshold is set at 100% which a stretch target set higher than national performance. **Exec Lead:** Adam Bateman **Committee:** RABD	100 %	R A G	<100 % N/A 100 %		No Action Required
Cancer RTT	**Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.** W Threshold is set at 100% which a stretch target set higher than national performance. **Exec Lead:** Adam Bateman **Committee:** RABD	100 %	R A G	<100 % N/A 100 %		No Action Required
Cancer RTT	**All Cancers: 31 day wait until subsequent treatments** W Threshold is set at 100% which a stretch target set higher than national performance. **Exec Lead:** Adam Bateman **Committee:** RABD	100 %	R A G	<100 % N/A 100 %		No Action Required

Delivery of Outstanding Care

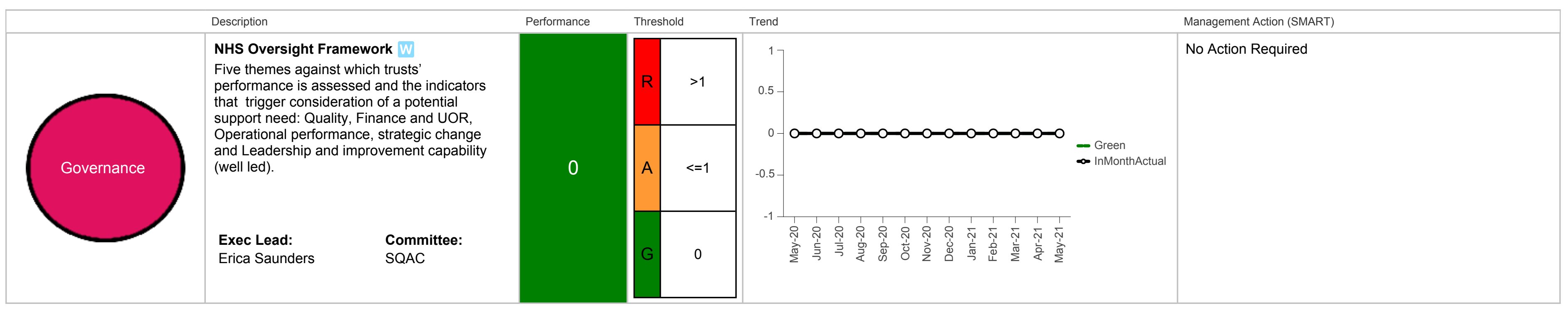
13.3 - PERFORMANCE - RESPONSIVE

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Cancer RTT	**31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)** W Threshold is set at 100% which a stretch target set higher than national performance. **Exec Lead:** Adam Bateman **Committee:** RABD	100 %	R <100 % A N/A G 100 %		No Action Required
Diagnostics	**Diagnostics: % Completed Within 6 Weeks** W Threshold is based on National Guidance set by NHS England at 99%. **Exec Lead:** Adam Bateman **Committee:** RABD	95.24 %	R <99 % A N/A G >=99 %		Scopes are still dealing with delays caused by the decontamination failure in theatres. Patients are being prioritised by clinical urgency presently but performance should improve from July. EEG the wait for VT assessments is still leading to some breaches with second bed waiting to come online, but we anticipate we will have some long waiters for next months whilst wait comes down.

14.1 - PERFORMANCE - WELL LED

D Drive W Watch P Programme



	Description	Performance	Threshold		Trend	Management Action (SMART)
Governance	**NHS Oversight Framework** W Five themes against which trusts' performance is assessed and the indicators that trigger consideration of a potential support need: Quality, Finance and UOR, Operational performance, strategic change and Leadership and improvement capability (well led). **Exec Lead:** Erica Saunders **Committee:** SQAC	0	R	>1		No Action Required
			A	<=1		
			G	0		

000143

The Best People doing their best Work

15.1 - PEOPLE - WELL LED

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Personal Development	**PDR** W Trust target, measuring compliance of staff Personal Development Reviews (Non medical). The Trust compliance period is set to be achieved in the first 4 months of each year (April -July). **Exec Lead:** Melissa Swindell **Committee:** PAWC	6.28 %	No Threshold		With 2 months left of the appraisal window, we're starting to see people completing their staff appraisals and recording them into ESR with just over 6% of appraisals having been completed up until this point. We've now run 4 PDR Workshops for reviewers and have 4 scheduled to take place over the coming weeks to ensure that managers are best equipped to have meaningful appraisal conversations and are prepared for the new addition of the wellbeing conversation. Regular reporting and updates will start to be seen at Organisational level.
Appraisal	**Medical Appraisal** W Trust Target for compliance for medical staff, which is on a rolling 12mth period. **Exec Lead:** Melissa Swindell **Committee:** PAWC	30.92 %	No Threshold		
Training	**Mandatory Training** W This is a Trust target that measures all required training including Resuscitation. **Exec Lead:** Melissa Swindell **Committee:** PAWC	87.21 %	R <80 % A >=80 % G >=90 %		Overall Mandatory Training has remained at 88% for this month, but is still steadily returning back to the target of 90% based on recent trajectory. As per previous updates our key areas of focus are practical topics with frequent refreshers that require face to face training to take place and our Estates and Ancillary staff as a wider staff group. We have seen some consistent steady improvements within Resus, now up to 74% overall but still a long way to go in both of the annual topics (Basic Life Support & PLS/APLS Annual Update) which are slowly improving.

The Best People doing their best Work

15.2 - PEOPLE - WELL LED

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Sickness	**Sickness** D % of staff who have been absent from work due to sickness, this is broken down into LTS & STS in further metrics **Exec Lead:** Melissa Swindell **Committee:** PAWC	5.13 %	R >4.5 % A <=4.5 % G <=4 %	Chart (May-20 to May-21): Actual, Average, UCL, LCL, UWL, LWL, Green	Sickness has risen this month by 0.5%, 0.2% due to long term sickness and 0.3% due to short term sickness. The HR team continue to work closely with managers and leaders across the Trust to provide advice and guidance and to ensure appropriate support is in place.
Sickness	**Short Term Sickness** D % of Trust staff who have been absent from work due to sickness lasting less than 28 days **Exec Lead:** Melissa Swindell **Committee:** PAWC	1.37 %	R >1 % A N/A G <=1 %	Chart (May-20 to May-21): Actual, Average, UCL, LCL, UWL, LWL, Green	As above
Sickness	**Long Term Sickness** D % of Trust staff who have been absent from work due to sickness lasting 28 days or more **Exec Lead:** Melissa Swindell **Committee:** PAWC	3.75 %	R >3 % A N/A G <=3 %	Chart (May-20 to May-21): Actual, Average, UCL, LCL, UWL, LWL, Green	As above

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15.3 - PEOPLE - WELL LED

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Temporary Spend	**Temporary Spend ('000s)** D Indicates the expenditure on premium temporary pay spend and monitors the reduction. **Exec Lead:** Melissa Swindell **Committee:** PAWC	1044.14	No Threshold		
Staff Turnover	**Staff Turnover** D Trust Target which is based on a rolling 12mth period **Exec Lead:** Melissa Swindell **Committee:** PAWC	10.76 %	R >11 % A <=11 % G <=10 %		Turnover has increased over the last few months as the contracts of the nursing students came to an end, this is expected to settle back to our usual numbers.

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16.1 - FINANCE - WELL LED

D Drive W Watch P Programme

	Description	Performance	Threshold		Trend	Management Action (SMART)
Finance	**Control Total In Month Variance (£'000s)** W Variance from Control Total plan. Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	592	R A G	<-20% >=-20% >=-5%		No Action Required
Finance	**Capital Expenditure In Month Variance (£'000s)** W Variance from capital plan. Variation between months is usual and the threshold of + or - 5% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	974	R A G	<-10% >=-10% >=-5%		No Action Required
Finance	**Cash in Bank (£'000s)** W Variance from Cash plan. Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	88,440	R A G	<-20% >=-20% >=-5%		No Action Required

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16.2 - FINANCE - WELL LED

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**Income In Month Variance (£'000s)** W Variance from income plan. Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	715	R <-20% A >=-20% G >=-5%		No Action Required
Finance	**Pay In Month Variance (£'000s)** W Variance from pay plan. Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	-370	R <-20% A >=-20% G >=-5%		No Action Required
Finance	**Non Pay In Month Variance (£'000s)** W Variance from non pay plan. Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	247	R <-20% A >=-20% G >=-5%		No Action Required

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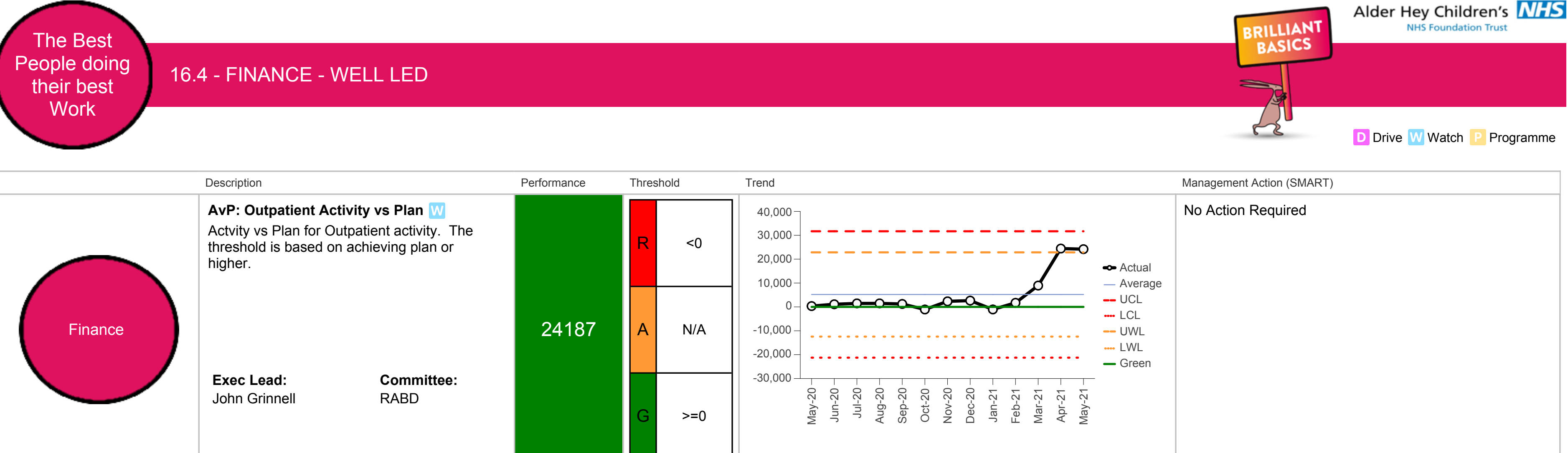
16.3 - FINANCE - WELL LED

D Drive W Watch P Programme

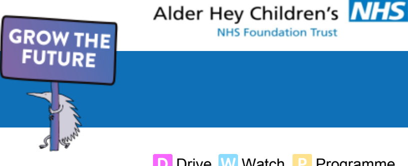
	Description	Performance	Threshold		Trend	Management Action (SMART)
Finance	**AvP: IP - Non-Elective** W Actvity vs Plan for Inpatient Non-Elective Activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	1260	R A G	<0 N/A >=0		No Action Required
Finance	**AvP: IP Elective vs Plan** W Actvity vs Plan for Inpatient Elective activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	434	R A G	<0 N/A >=0		No Action Required
Finance	**AvP: Daycase Activity vs Plan** W Actvity vs Plan for Daycase activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	1793	R A G	<0 N/A >=0		No Action Required



	Description	Performance	Threshold		Trend	Management Action (SMART)
Finance	**AvP: Outpatient Activity vs Plan** W Actvity vs Plan for Outpatient activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	24187	R	<0		No Action Required
			A	N/A		
			G	>=0		

Game Changing Research & Innovation

17.1 - RESEARCH & DEVELOPMENT - WELL LED

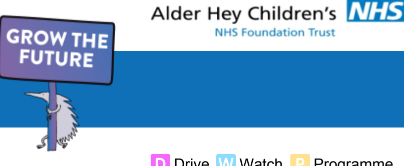


D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Clinical Research	**Number of Open Studies - Academic** W Number of academic studies currently open. **Exec Lead:** Jo Blair **Committee:** RMB	103	R <111 A >=111 G >=130	Chart: Actual, Average, UCL, LCL, UWL, LWL, Green; May-20 to May-21	On track with the planned increase in the number of open academic studies.
Clinical Research	**Number of Open Studies - Commercial** W Number of commercial studies currently open. **Exec Lead:** Jo Blair **Committee:** RMB	36	R <21 A >=21 G >=30	Chart: Actual, Average, UCL, LCL, UWL, LWL, Green; May-20 to May-21	No Action Required
Clinical Research	**Number of New Studies Opened - Academic** W Number of new academic studies opened in month. **Exec Lead:** Jo Blair **Committee:** RMB	2	R <2 A >=2 G >=3	Chart: Actual, Average, UCL, LCL, UWL, LWL, Green; May-20 to May-21	Minor reduction in opening new, academic studies to enable capacity to open new commercial studies.

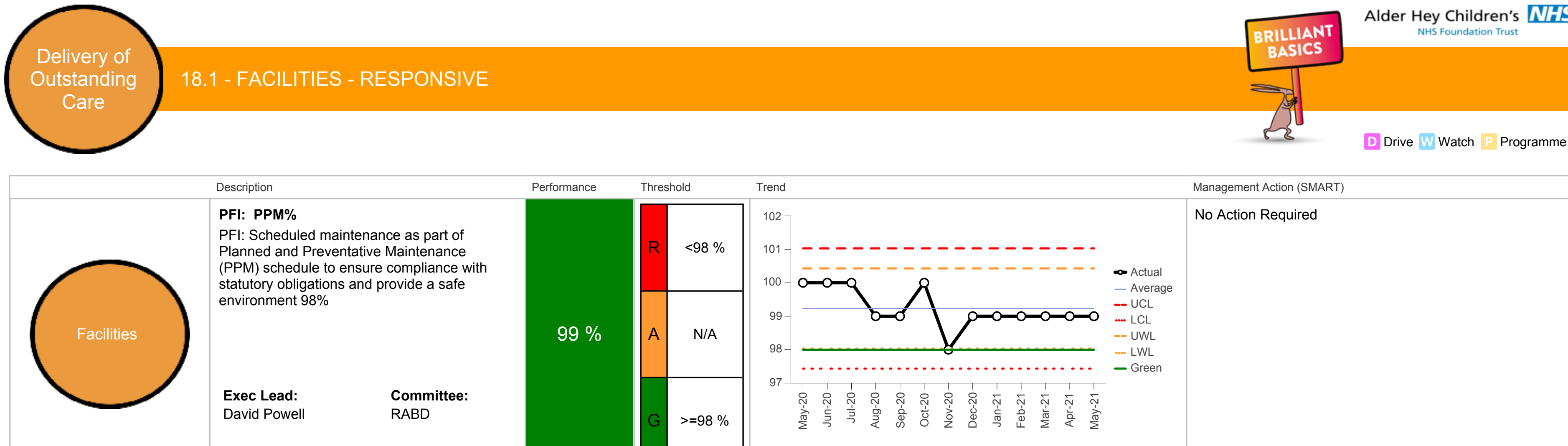
Game Changing Research & Innovation

17.2 - RESEARCH & DEVELOPMENT - WELL LED

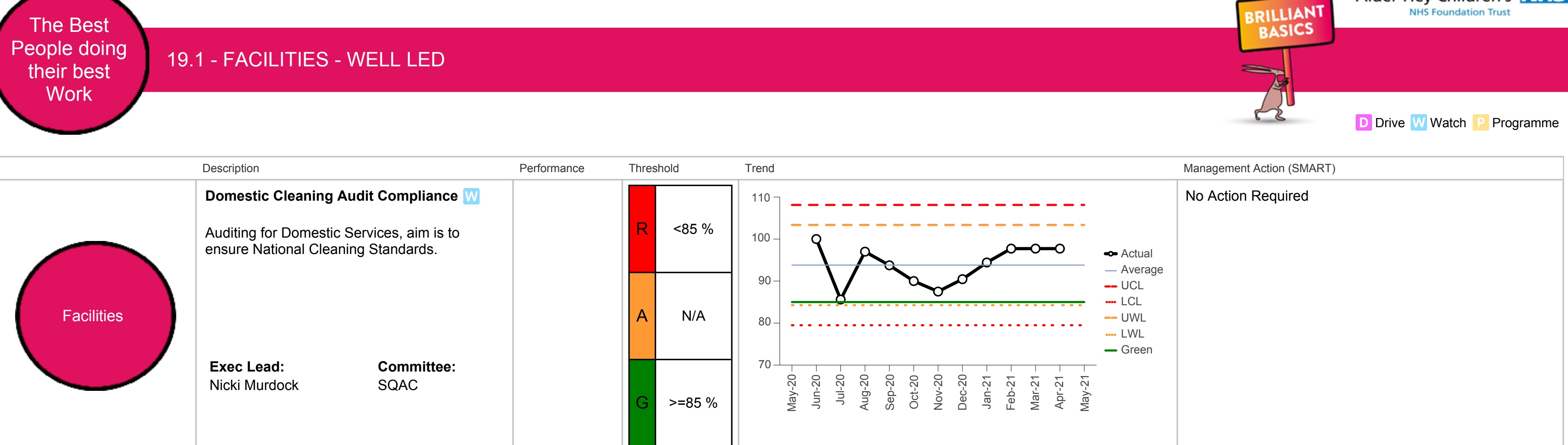


D Drive W Watch P Programme

	Description	Performance	Threshold		Trend	Management Action (SMART)
Clinical Research	**Number of New Studies Opened - Commercial** W Number of new commercial studies opened in month. **Exec Lead:** Jo Blair **Committee:** RMB	3	R	<1		No Action Required
			A	N/A		
			G	>=1		
Clinical Research	**Number of patients recruited** W Number of patients recruited to NIHR portfolio studies in month. **Exec Lead:** Jo Blair **Committee:** RMB	889	R	<86		No Action Required
			A	>=86		
			G	>=100		



Description	Performance	Threshold		Trend	Management Action (SMART)
PFI: PPM% PFI: Scheduled maintenance as part of Planned and Preventative Maintenance (PPM) schedule to ensure compliance with statutory obligations and provide a safe environment 98% **Exec Lead:** David Powell **Committee:** RABD	99 %	R	<98 %		No Action Required
		A	N/A		
		G	>=98 %		



The Best People doing their best Work

19.1 - FACILITIES - WELL LED

	Description	Performance	Threshold	Trend	Management Action (SMART)
Facilities	**Domestic Cleaning Audit Compliance** W Auditing for Domestic Services, aim is to ensure National Cleaning Standards. **Exec Lead:** Nicki Murdock **Committee:** SQAC		R <85 % A N/A G >=85 %		No Action Required

All Divisions

D Drive W Watch P Programme

SAFE

		COMMUNITY	MEDICINE	SURGERY	RAG
Clinical Incidents resulting in Near Miss	D	12	33	34	No Threshold
Clinical Incidents resulting in No Harm	D	55	121	164	No Threshold
Clinical Incidents resulting in minor, non permanent harm	D	20	23	31	No Threshold
Clinical Incidents resulting in moderate, semi permanent harm	D	0	2	2	No Threshold
Clinical Incidents resulting in severe, permanent harm	D	0	1	0	0 / N/A / >0
Clinical Incidents resulting in catastrophic, death	D	0	0	0	0 / N/A / >0
Medication errors resulting in harm	D	0	0	3	No Threshold
Pressure Ulcers (Category 3)	W	0	0	0	0 / N/A / >0
Pressure Ulcers (Category 4)	W	0	0	0	0 / N/A / >0
Never Events	W	0	0	0	0 / N/A / >0
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients	D P		88.2%	91.7%	>=90 % / N/A / <90 %
Hospital Acquired Organisms - MRSA (BSI)	D	0	0	0	0 / N/A / >0
Hospital Acquired Organisms - C.difficile	D	0	1	0	0 / N/A / >0
Hospital Acquired Organisms - MSSA	D	0	0	1	No Threshold

CARING

		COMMUNITY	MEDICINE	SURGERY	RAG
Complaints	W	0	5	4	No Threshold
PALS	W	49	23	42	No Threshold

EFFECTIVE

		COMMUNITY	MEDICINE	SURGERY	RAG
% Readmissions to PICU within 48 hrs	W			0.0%	No Threshold
ED: 95% Treated within 4 Hours	D		81.1%		>=95 % / N/A / <95 %
ED: Number of patients spending >12 hours from decision to admit to admission	W		0		0 / N/A / >0

All Divisions

D Drive W Watch P Programme

		COMMUNITY	MEDICINE	SURGERY	RAG		
On the day Elective Cancelled Operations for Non Clinical Reasons	D	0	0	7	No Threshold		
28 Day Breaches	W	0	0	3	0	N/A	>0

RESPONSIVE

		COMMUNITY	MEDICINE	SURGERY	RAG		
IP Survey: % Received information enabling choices about their care	W		98.3%	97.9%	>=95 %	>=90 %	<90 %
IP Survey: % Treated with respect	W		100.0%	98.6%	>=95 %	>=90 %	<90 %
IP Survey: % Know their planned date of discharge	D P		91.5%	92.5%	>=90 %	>=85 %	<85 %
IP Survey: % Know who is in charge of their care	W		100.0%	97.9%	>=95 %	>=90 %	<90 %
IP Survey: % Patients involved in Play	D		88.1%	76.7%	>=90 %	>=85 %	<85 %
IP Survey: % Patients involved in Learning	D		89.8%	92.5%	>=90 %	>=85 %	<85 %
RTT: Open Pathway: % Waiting within 18 Weeks	W	74.0%	93.1%	64.2%	>=92 %	>=90 %	<90 %
Waiting List Size	W	765	2,819	7,980	No Threshold		
Waiting Greater than 52 weeks - Incomplete Pathways	W	0	3	232	0	N/A	>0
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	W		100.0%		100 %	N/A	<100 %
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	W		100.0%		100 %	N/A	<100 %
All Cancers: 31 day wait until subsequent treatments	W		100.0%		100 %	N/A	<100 %
Diagnostics: % Completed Within 6 Weeks	W		95.1%	100.0%	>=99 %	N/A	<99 %
31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)	W		100.0%		100 %	N/A	<100 %

WELL LED

		COMMUNITY	MEDICINE	SURGERY	RAG
Control Total In Month Variance (£'000s)	W	212	200	199	No Threshold
Income In Month Variance (£'000s)	W	88	-26	49	No Threshold
Pay In Month Variance (£'000s)	W	-49	60	21	No Threshold
Non Pay In Month Variance (£'000s)	W	173	166	130	No Threshold

All Divisions

D Drive W Watch P Programme

		COMMUNITY	MEDICINE	SURGERY	RAG		
AvP: IP - Non-Elective	W		791	469	>=0	N/A	<0
AvP: IP Elective vs Plan	W		166	268	>=0	N/A	<0
AvP: Daycase Activity vs Plan	W		1,133	660	>=0	N/A	<0
AvP: Outpatient Activity vs Plan	W	4,381	7,025	10,808	>=0	N/A	<0
PDR	W	1.5%	6.8%	9.0%	No Threshold		
Medical Appraisal	W	24.0%	28.6%	34.8%	No Threshold		
Mandatory Training	W	91.0%	87.6%	87.1%	>=90 %	>=80 %	<80 %
Sickness	D	3.8%	5.2%	5.6%	<=4 %	<=4.5 %	>4.5 %
Short Term Sickness	D	1.2%	1.3%	1.7%	<=1 %	N/A	>1 %
Long Term Sickness	D	2.6%	3.8%	3.9%	<=3 %	N/A	>3 %
Temporary Spend ('000s)	D	192	262	459	No Threshold		
Staff Turnover	D	9.5%	7.7%	9.8%	<=10 %	<=11 %	>11 %
Safer Staffing (Shift Fill Rate)	W	99.1%	97.9%	99.2%	>=90 %	>=80 %	<90 %

Medicine Division

SAFE		**Highlight** • Overall incidents reduced in May **Challenges** • Inpatient sepsis w/in 60 mins at 88.2% in May • Pharmacy outpatient dispensing remains below 90% • Increase in medication errors from 29 to 41
CARING		**Highlight** • PALS and complaints remain steady following reduction in April. **Challenges** • Complexity of complaints remains a challenge for turnaround of responses.
EFFECTIVE	ED improvement action plan being managed through our weekly service meeting with the ED department leads. Key actions involve the establishment of additional streams for management of low acuity patients and improvement to the triage process.	**Highlight** • No 28 day breaches despite high cancellations in April due to decon issues in theatres. **Challenges** • WNB rate impacting on recovery and still highest for our new patients. • ED performance challenged at 81% due to high number of attendances w/o necessary support from primary care
RESPONSIVE	The outsourcing of some cross sectional radiology performance in May has led to a massive reduction in our reporting waits. We will maintain this through continued outsourcing and increased sessions to consultants through the recovery and accelerator bid funds.	**Highlight** ▪ IP survey responses improved for play which was red. ▪ Maintained excellent performance against cancer standards including new faster diagnosis standard. ▪ RTT still above 92% with **Challenges** ▪ Improvement in radiology reporting from 6 weeks to 2.5 with outsourcing in place but still outside of 2 weeks. ▪ Challenges in individual services (gastro, neuro and derm) to achieve RTT standards within capacity) ▪ Eppf completion on the day of attendance remains a challenge.
WELL LED	PDRs and Big Conversation actions remain a key focus in the Divisional Team. We've been continuing our engagement with teams through our monthly service presentations with the Allergy team presenting to team in May, and Pathology and Radiology both having done theirs in June.	**Highlight** • Achieving activity plans and financial targets for M1 and M2 **Challenges** • Increase in short term sickness • Carrying vacancies in key areas due to difficulty in recruiting.

Alder Hey Children's NHS Foundation Trust

Medicine

D Drive W Watch P Programme

SAFE

		May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss	D	19	18	29	19	17	28	34	22	18	24	33	41	33		No Threshold
Clinical Incidents resulting in No Harm	D	64	76	104	76	94	70	126	99	89	96	126	122	121		No Threshold
Clinical Incidents resulting in minor, non permanent harm	D	13	18	26	20	16	11	18	19	22	17	19	23	23		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm	D	0	0	2	0	0	0	0	0	0	1	1	0	2		No Threshold
Clinical Incidents resulting in severe, permanent harm	D	0	0	0	1	0	0	0	0	1	0	0	0	1		0 N/A >0
Clinical Incidents resulting in catastrophic, death	D	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Medication errors resulting in harm	D	5	3	2	0	4	0	0	0	4	1	2	0	0		No Threshold
Medication Errors (Incidents)		25	29	26	23	19	24	32	36	34	28	39	29	41		No Threshold
Pressure Ulcers (Category 3)	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Pressure Ulcers (Category 4)	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Acute readmissions of patients with long term conditions within 28 days		1	0	0	2	2	0	0	1	0	2	4	1	3		No Threshold
Never Events	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients	D P	83.3%	92.3%	100.0%	84.6%	91.7%	100.0%	75.0%	90.9%	83.3%	84.6%	87.5%	90.9%	88.2%		>=90 % N/A <90 %
Pressure Ulcers (Category 3 and above)		0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - MRSA (BSI)	D	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - C.difficile	D	0	0	0	0	0	1	0	0	0	0	0	0	1		0 N/A >0
Hospital Acquired Organisms - CLABSI		1	1	0	2	0	0	0	2	2	2	1	5	0		No Threshold
Hospital Acquired Organisms - MSSA	D	0	0	0	0	0	0	0	0	1	1	0	0	0		No Threshold
Cleanliness Scores			98.5%	97.7%	97.8%	98.0%	98.0%	96.0%	95.1%	98.4%	97.2%	98.6%	98.7%	98.2%		No Threshold
Pharmacy - ASU (Aseptic Service Unit) Environmental Monitoring to include ranking within the region.		99.3%	99.6%	99.8%	99.8%	99.8%	99.8%	99.7%								>=95 % N/A <95 %
Pharmacy - NPP (Near Patient Pharmacy) Medicines Reconciliation, percentage completed.		57.4%	60.0%	63.8%	63.8%	63.8%	49.3%	64.6%	71.3%	53.9%	68.2%					>=50 % N/A <50 %
Pharmacy - Dispensing for Out Patients - Routine within 30 minutes		65.0%	64.0%	78.5%	84.0%	77.3%	85.0%	85.0%	85.0%	85.0%	84.0%					>=90 % N/A <90 %
Pharmacy - Dispensing for Out Patients - Complex within 60 minutes		69.0%	100.0%	100.0%	100.0%	100.0%	100.0%	77.0%		100.0%	100.0%					>=90 % N/A <90 %

CARING

		May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Last 12 Months	RAG
Complaints	W	2	6	1	11	7	8	7	6	8	3	12	5	5		No Threshold
PALS	W	18	21	32	49	27	24	28	27	22	18	37	23	23		No Threshold

EFFECTIVE

		May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Last 12 Months	RAG
Referrals Received (Total)		994	1,436	1,669	1,571	2,283	2,021	2,094	1,696	2,078	1,672	2,210	2,094	2,126		No Threshold
ED: 95% Treated within 4 Hours	D	97.8%	98.5%	97.3%	97.7%	95.1%	96.8%	97.1%	98.6%	98.5%	97.7%	95.3%	92.5%	81.1%		>=95 % N/A <95 %
ED: Percentage Left without being seen	W	0.8%	1.1%	1.5%	0.8%	2.0%	0.8%	1.0%	0.6%	0.5%	0.7%	2.2%	3.8%	7.4%		<=5 % N/A >5 %
ED: All handovers between ambulance and A & E - Waiting more than 30 minutes	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
ED: All handovers between ambulance and A & E - Waiting more than 60 minutes	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
ED: Re-attendance within 7 days of original attendance (%)	W	8.4%	7.5%	7.8%	8.3%	7.0%	7.9%	7.8%	7.9%	9.0%	7.9%	7.5%	8.3%	9.5%		No Threshold

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Alder Hey Children's NHS
NHS Foundation Trust

Medicine

D Drive W Watch P Programme

		May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Last 12 Months	RAG		
ED: Number of patients spending >12 hours from decision to admit to admission	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0
Theatre Utilisation - % of Session Utilised	W	76.7%	75.4%	82.0%	82.1%	81.3%	83.6%	82.2%	84.7%	84.0%	87.0%	82.6%	84.6%	80.3%		>=90 %	>=80 %	<80 %
On the day Elective Cancelled Operations for Non Clinical Reasons	D	2	0	0	3	2	1	1	2	0	0	1	2	0		No Threshold		
28 Day Breaches	W	1	2	0	0	3	2	0	0	1	0	0	0	0		0	N/A	>0
Hospital Initiated Clinic Cancellations < 6 weeks notice		1	2	12	55	20	33	20	47	16	14	18	0	0		No Threshold		
OP Appointments Cancelled by Hospital %		21.8%	15.6%	13.1%	11.4%	12.3%	11.2%	12.4%	13.7%	12.1%	12.1%	11.8%	9.8%	10.1%		<=5 %	N/A	>10 %
Was Not Brought Rate	W P	8.4%	11.2%	11.3%	11.8%	11.7%	11.2%	9.5%	10.4%	9.7%	9.4%	8.9%	9.8%	10.5%		<=12 %	<=14 %	>14 %
Was Not Brought Rate (New Appts)	W	13.3%	14.4%	14.8%	13.1%	15.8%	12.3%	11.3%	11.4%	11.9%	10.9%	9.3%	12.6%	11.0%		<=10 %	<=12 %	>12 %
Was Not Brought Rate (Followup Appts)	W	7.4%	10.5%	10.5%	11.5%	10.9%	10.9%	9.0%	10.1%	9.2%	9.1%	8.8%	9.2%	10.4%		<=14 %	<=16 %	>16 %
Coding average comorbidities		5.46	5.39	5.33	5.28	5.17	5.31	5.45	5.50	5.45	5.54	5.41	5.14	5.17		No Threshold		

RESPONSIVE

		May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Last 12 Months	RAG		
IP Survey: % Received information enabling choices about their care	W	100.0%	81.5%	100.0%	95.6%	92.9%	92.9%	96.9%	95.8%	100.0%	96.4%	95.2%	96.2%	98.3%		>=95 %	>=90 %	<90 %
IP Survey: % Treated with respect	W	100.0%	88.9%	96.8%	97.8%	100.0%	97.2%	100.0%	95.8%	100.0%	100.0%	95.2%	98.1%	100.0%		>=95 %	>=90 %	<90 %
IP Survey: % Know their planned date of discharge	D P	97.1%	85.2%	100.0%	93.3%	95.2%	88.9%	100.0%	91.7%	96.9%	98.2%	91.9%	96.2%	91.5%		>=90 %	>=85 %	<85 %
IP Survey: % Know who is in charge of their care	W	97.1%	85.2%	90.3%	100.0%	97.6%	100.0%	100.0%	87.5%	100.0%	92.9%	95.2%	94.3%	100.0%		>=95 %	>=90 %	<90 %
IP Survey: % Patients involved in Play	D	74.3%	63.0%	77.4%	80.0%	88.1%	77.8%	84.4%	81.2%	75.0%	89.3%	85.5%	84.9%	88.1%		>=90 %	>=85 %	<85 %
IP Survey: % Patients involved in Learning	D	68.6%	77.8%	87.1%	82.2%	76.2%	63.9%	62.5%	81.2%	93.8%	94.6%	80.0%	90.6%	89.8%		>=90 %	>=85 %	<85 %
RTT: Open Pathway: % Waiting within 18 Weeks	W	60.1%	46.3%	40.6%	45.0%	55.5%	68.0%	81.0%	86.1%	89.5%	90.8%	92.9%	92.0%	93.1%		>=92 %	>=90 %	<90 %
Waiting List Size	W	3,266	2,791	2,484	2,420	2,151	1,916	1,778	1,785	1,731	2,110	2,280	2,509	2,819		No Threshold		
Waiting Greater than 52 weeks - Incomplete Pathways	W	0	0	0	0	0	0	0	0	1	16	4	4	3		0	N/A	>0
Waiting Times - 40 weeks and above		121	127	147	181	137	81	63	24	9	37	10	24	12		No Threshold		
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	W	100.0%	100.0%	95.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 %	N/A	<100 %
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 %	N/A	<100 %
All Cancers: 31 day wait until subsequent treatments	W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 %	N/A	<100 %
Diagnostics: % Completed Within 6 Weeks	W	64.9%	82.1%	84.6%	77.9%	91.4%	96.2%	97.7%	91.7%	94.6%	96.0%	97.7%	95.5%	95.1%		>=99 %	N/A	<99 %
31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)	W	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 %	N/A	<100 %
Pathology - % Turnaround times for urgent requests < 1 hr		90.4%	90.0%	90.4%	92.7%	89.7%	90.0%	90.6%	90.4%	90.4%	90.4%	91.9%	91.1%	92.6%		>=90 %	>=85 %	<90 %
Pathology - % Turnaround times for non-urgent requests < 24hrs		100.0%	100.0%	99.9%	100.0%	100.0%	100.0%	99.8%	100.0%	99.9%	100.0%	100.0%	100.0%	99.5%		>=90 %	>=85 %	<90 %
Imaging - % Report Turnaround times GP referrals < 24 hrs		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		>=95 %	>=90 %	<95 %
Imaging - % Reporting Turnaround Times - ED		100.0%	100.0%	100.0%	98.0%	100.0%	100.0%	97.0%	95.0%	99.0%	99.0%	100.0%	89.0%	96.0%		>=90 %	>=85 %	<90 %
Imaging - % Reporting Turnaround Times - Inpatients		98.0%	98.0%	97.0%	97.0%	98.0%	93.0%	98.0%	92.0%	99.0%	98.0%	99.0%	89.0%	96.0%		>=90 %	>=85 %	<90 %
Imaging - % Reporting Turnaround Times - Outpatients		98.0%	97.0%	81.0%	69.0%	71.0%	74.0%	72.0%	51.0%	75.0%	77.0%	58.0%	65.0%	57.0%		>=85 %	N/A	<85 %
Imaging - Waiting Times - MRI % First Diagnostics seen within 6 weeks		63.6%	62.6%	82.4%	59.1%	98.0%	98.8%	100.0%	94.2%	100.0%	95.0%	98.0%	98.7%	100.0%		>=99 %	N/A	<99 %
Imaging - Waiting Times - CT % First Diagnostics seen within 6 weeks		17.2%	35.4%	88.2%	77.8%	100.0%	100.0%	100.0%	90.0%	100.0%	100.0%	100.0%	100.0%	100.0%		>=99 %	N/A	<99 %
Imaging - Waiting Times - Ultrasound % First Diagnostics seen within 6 weeks		70.7%	83.8%	86.4%	95.0%	92.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.9%	100.0%		>=99 %	N/A	<99 %

Medicine

D Drive W Watch P Programme

WELL LED

		May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	W	-1,842	-1,048	278	-1,111	-1,201	-264	153	41	189	160	-586	263	200		No Threshold
Income In Month Variance (£'000s)	W	-2,220	-1,103	347	-1,170	-622	-647	561	142	10	36	170	37	-26		No Threshold
Pay In Month Variance (£'000s)	W	99	92	196	62	-211	-143	338	30	-61	-52	-148	-64	60		No Threshold
AvP: IP - Non-Elective	W	0	-1	0	1	-222	-333	-421	-355	-411	-410	65	702	791		>=0 N/A <0
AvP: IP Elective vs Plan	W	-1	0	0	0	24	7	25	47	2	42	77	147	166		>=0 N/A <0
AvP: OP New		7.00	5.00	0.00	15.00	-455.00	-6.00	57.00	-111.05	-321.00	-53.00	366.00	1,111.00	1,151.00		>=0 N/A <0
AvP: OP FollowUp		32.00	36.00	89.00	47.00	1,341.00	748.00	896.00	1,108.29	669.00	939.00	1,798.00	5,074.00	4,906.00		>=0 N/A <0
AvP: Daycase Activity vs Plan	W	1	2	0	2	15	-5	143	106	-74	54	385	1,209	1,133		>=0 N/A <0
AvP: Outpatient Activity vs Plan	W	39	41	92	66	637	261	737	782	-244	692	2,191	7,229	7,025		>=0 N/A <0
PDR	W	3.1%	10.7%	12.1%	23.0%	21.8%	60.2%	69.1%	74.6%	74.2%	74.2%	74.2%	2.6%	6.8%		No Threshold
Medical Appraisal	W	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	94.1%	94.1%	94.1%	94.1%	23.4%	28.6%		No Threshold
Mandatory Training	W	91.9%	91.6%	91.3%	91.3%	89.9%	90.2%	88.9%	86.7%	88.1%	87.1%	88.5%	89.1%	87.6%		>=90 % >=80 % <80 %
Sickness	D	4.8%	5.4%	5.6%	5.1%	5.0%	5.8%	4.7%	4.9%	6.3%	5.1%	4.2%	4.4%	5.2%		<=4 % <=4.5 % >4.5 %
Short Term Sickness	D	0.9%	1.0%	0.9%	1.1%	1.4%	2.2%	1.5%	1.2%	2.0%	1.4%	1.1%	1.2%	1.3%		<=1 % N/A >1 %
Long Term Sickness	D	3.9%	4.4%	4.7%	4.1%	3.6%	3.6%	3.3%	3.7%	4.3%	3.7%	3.1%	3.3%	3.8%		<=3 % N/A >3 %
Temporary Spend ('000s)	D	157	108	167	217	266	235	239	213	247	267	261	210	262		No Threshold
Staff Turnover	D	9.1%	8.2%	7.5%	7.5%	6.6%	6.6%	7.0%	7.3%	6.8%	6.7%	6.2%	6.6%	7.7%		<=10 % <=11 % >11 %
Safer Staffing (Shift Fill Rate)	W		97.7%	96.4%	94.9%	94.9%	93.2%	93.6%	93.2%	91.2%	97.8%	93.9%	101.7%	97.9%		>=90 % >=80 % <90 %

Surgery Division

SAFE	• Slight increase in clinical incidents resulting in near miss 46>27<34 • Consistent number of clinical incidents resulting in No harm 173>164>163 • Reduction in Clinical Incidents resulting in minor, non-permanent harm 34<37>31 • No Clinical Incidents resulting in severe, permanent harm • No Clinical incidents resulting in catastrophic, death • Reduction in medication errors that resulting in harm 2:2<4>3 • Overall reduction in all medication errors 46>44>36 • No never events • Cleanliness scores 97%<99%>98%	**Highlight** • Significant improvement in patients treated for sepsis within 60 mins 90.9%>76.9%<91.7% • No pressure ulcers, cat 3 & 4 since Jan 2021 **Challenges** • 2 clinical incidents resulting in moderate, semi-permanent harm, 0<1<2 • One hospital acquired organisms- MSSA, first in 4 consecutive months
CARING	• Increase in formal complaints received 3<7>0<4 • Slight increase in PALS 27<34<42	**Highlight** • Launch of QR codes for patient leaflets in Orthopaedics **Challenges** • Providing access within a timely manner for elective patients
EFFECTIVE	• No patients readmitted to PICU within 48 hours for two consecutive months • 3 patients waited over 28 days from their cancelled procedure to be rescheduled 2<4>3 • Increase in WNB rate increased 7.3%>7.1%<8.9% • Slight increase in Theatre Utilisation 84.1%<88.8%	**Highlight** • Reduction in the number of patients cancelled on the day of their procedure 11:11<7 • CCAD cases 34:34>31 **Challenges** • Continued increase in referrals received 2,875<3,967> 3,864<3,901
RESPONSIVE	• Increase % Received information enabling choices about their care 99%>92%<96%<98% • Patients who noted that they were treated with respect 94%<98%:98% • Patients knew their planned date of discharge 95%<99%>93% • Patients noted that they knew who was in charge of their care 97%<100%>98% • Increase in patients noted they were involved in learning 96%>91%<93% • Growth in patients waiting to commence treatment (Waiting list size) 8,701>7,773<7,980	**Highlight** • Reduction in patients waiting over 52 weeks to commence treatment 357>276>232 • Continued improvement in RTT%, 56%<62%:62%<64% • Consultant recruitment in Craniofacial and Ophthalmology to improve access and sustainability **Challenges** • Increase OP and IP capacity required to recover waiting time position
WELL LED	• Roll out of New PDR season 0.1%<9% • Increase Medical appraisals 24%<35% • Mandatory training maintained at 87% • Slight increase in staff turnover7.8%<8%<9.7% • Sickness rates remain stable 5.4%>5.2%<5.6% • Long term sickness 3.9%>3.7%<3.9% • Short term sickness 1.5%:1.5%<1.7%	**Highlight** • Delivery of IP and OP activity plan against 2019/20 baseline • Significant reduction in patients waiting over 52 weeks to commence treatment in most cancelled areas including ENT, Dental, Pain and Ortho **Challenges** • Establishing increased capacity which is sustainable for all staff groups

Alder Hey Children's NHS Foundation Trust

Surgery

D Drive W Watch P Programme

SAFE

		May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss	D	17	29	40	23	21	27	46	31	24	26	45	27	34		No Threshold
Clinical Incidents resulting in No Harm	D	95	114	176	151	140	155	190	143	107	140	174	167	164		No Threshold
Clinical Incidents resulting in minor, non permanent harm	D	26	48	47	52	38	36	45	42	37	27	34	34	31		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm	D	0	0	4	1	0	0	0	1	1	0	0	1	2		No Threshold
Clinical Incidents resulting in severe, permanent harm	D	0	0	0	1	0	0	0	0	0	0	0	0	0		0 N/A >0
Clinical Incidents resulting in catastrophic, death	D	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Medication errors resulting in harm	D	0	4	4	1	4	1	11	0	1	2	2	4	3		No Threshold
Medication Errors (Incidents)		22	34	62	36	37	38	68	44	23	40	46	44	36		No Threshold
Pressure Ulcers (Category 3)	W	0	0	2	0	0	0	0	1	0	0	0	0	0		0 N/A >0
Pressure Ulcers (Category 4)	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Never Events	W	0	0	0	0	0	0	0	0	0	0	1	0	0		0 N/A >0
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients	D P	91.7%	88.9%	83.3%	85.7%	75.0%	86.7%	90.0%	53.8%	91.7%	83.3%	90.9%	76.9%	91.7%		>=90 % N/A <90 %
Pressure Ulcers (Category 3 and above)		0	0	2	0	0	0	0	1	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - MRSA (BSI)	D	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - C.difficile	D	0	0	0	0	1	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - MSSA	D	0	0	1	4	1	0	1	0	2	0	0	0	1		No Threshold
Cleanliness Scores			97.9%	98.4%	96.0%	98.2%	98.0%	96.0%	97.9%	98.9%	97.0%	97.9%	98.9%	98.4%		No Threshold

CARING

		May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Last 12 Months	RAG
Complaints	W	2	2	0	7	2	10	4	2	2	3	7	0	4		No Threshold
PALS	W	7	37	39	33	22	29	22	23	11	21	27	34	42		No Threshold

EFFECTIVE

		May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Last 12 Months	RAG
Readmissions to PICU within 48 hrs	D	0	2	1	0	0	1	2	1	0	0	1	0	0		No Threshold
% Readmissions to PICU within 48 hrs	W	0.0%	4.0%	1.4%	0.0%	0.0%	1.6%	4.2%	1.4%	0.0%	0.0%	1.6%	0.0%			No Threshold
Referrals Received (Total)		1,785	2,261	2,845	2,611	3,204	3,039	2,972	2,805	2,677	2,876	3,969	3,869	3,909		No Threshold
Theatre Utilisation - % of Session Utilised	W	68.1%	86.6%	88.6%	89.1%	88.8%	89.2%	88.6%	85.0%	87.6%	90.3%	89.5%	84.1%	88.8%		>=90 % >=80 % <80 %
On the day Elective Cancelled Operations for Non Clinical Reasons	D	3	3	7	15	15	18	15	8	5	7	11	11	7		No Threshold
28 Day Breaches	W	0	0	0	0	5	0	1	3	2	1	2	4	3		0 N/A >0
Hospital Initiated Clinic Cancellations < 6 weeks notice		2	0	16	70	52	58	38	45	38	50	37	0	0		No Threshold
OP Appointments Cancelled by Hospital %		30.2%	17.4%	15.1%	12.1%	11.4%	11.1%	11.9%	10.6%	10.5%	10.8%	11.8%	10.2%	10.5%		<=5 % <=10 % >10 %
Was Not Brought Rate	W P	9.7%	7.3%	8.3%	9.0%	9.4%	9.0%	8.7%	10.1%	10.4%	8.0%	7.3%	7.0%	8.9%		<=12 % <=14 % >14 %
Was Not Brought Rate (New Appts)	W	11.0%	8.4%	10.1%	10.5%	11.5%	9.4%	9.4%	11.7%	11.6%	10.5%	8.5%	7.4%	9.9%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts)	W	9.2%	6.8%	7.7%	8.5%	8.7%	8.8%	8.4%	9.5%	10.0%	7.1%	6.8%	6.8%	8.4%		<=14 % <=16 % >16 %
Coding average comorbidities		4.89	4.19	4.06	4.50	4.46	4.39	4.40	4.48	4.41	4.44	4.54	4.63	4.31		No Threshold
CCAD Cases		26	27	30	32	31	31	27	28	25	29	34	34	31		No Threshold

Surgery

D Drive W Watch P Programme

RESPONSIVE

		May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Last 12 Months	RAG
IP Survey: % Received information enabling choices about their care	W	88.7%	97.8%	99.0%	96.0%	96.2%	96.2%	95.3%	99.2%	99.0%	92.0%	95.8%	95.9%	97.9%		>=95 % / >=90 % / <90 %
IP Survey: % Treated with respect	W	96.2%	95.7%	99.0%	98.0%	94.7%	98.8%	98.1%	99.2%	100.0%	97.0%	94.4%	98.6%	98.6%		>=95 % / >=90 % / <90 %
IP Survey: % Know their planned date of discharge	D P	94.3%	98.9%	98.1%	93.1%	97.7%	100.0%	97.2%	98.4%	99.0%	98.0%	95.1%	99.3%	92.5%		>=90 % / >=85 % / <85 %
IP Survey: % Know who is in charge of their care	W	86.8%	92.4%	91.3%	99.0%	98.5%	100.0%	99.1%	95.9%	100.0%	96.0%	96.5%	100.0%	97.9%		>=95 % / >=90 % / <90 %
IP Survey: % Patients involved in Play	D	81.1%	65.2%	71.2%	82.2%	80.5%	85.7%	85.0%	72.1%	81.9%	84.0%	75.0%	79.7%	76.7%		>=90 % / >=85 % / <85 %
IP Survey: % Patients involved in Learning	D	56.6%	85.9%	81.7%	76.2%	75.2%	98.8%	74.8%	82.0%	95.2%	92.0%	95.8%	91.2%	92.5%		>=90 % / >=85 % / <85 %
RTT: Open Pathway: % Waiting within 18 Weeks	W	59.6%	47.8%	40.3%	43.2%	46.8%	50.9%	53.4%	54.3%	54.5%	56.2%	61.8%	61.6%	64.2%		>=92 % / >=90 % / <90 %
Waiting List Size	W	6,630	7,186	7,431	7,840	7,737	8,127	8,221	7,858	8,132	8,432	8,701	7,773	7,980		No Threshold
Waiting Greater than 52 weeks - Incomplete Pathways	W	31	60	137	121	135	143	147	183	221	291	357	276	232		0 / N/A / >0
Diagnostics: % Completed Within 6 Weeks	W	92.9%	66.7%	53.3%	100.0%	100.0%	100.0%	87.5%	100.0%	50.0%	90.0%	94.1%	91.3%	100.0%		>=99 % / N/A / <99 %

WELL LED

		May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	W	-3,714	-1,773	-1,983	-1,540	-1,990	-487	54	-502	-245	11	-857	-734	199		No Threshold
Income In Month Variance (£'000s)	W	-4,172	-1,908	-1,964	-1,428	-1,460	15	1	34	0	83	152	47	49		No Threshold
Pay In Month Variance (£'000s)	W	-111	32	67	35	-457	-68	-67	-398	-364	-169	-549	-608	21		No Threshold
AvP: IP - Non-Elective	W	0	1	0	-1	-127	-65	-35	-47	-89	-47	47	496	469		>=0 / N/A / <0
AvP: IP Elective vs Plan	W	1	-1	0	-1	25	3	-16	4	-47	-56	91	263	268		>=0 / N/A / <0
AvP: OP New		12.00	13.00	28.00	32.00	-674.00	-1,266.00	-632.00	-469.19	-972.00	-447.00	587.00	2,516.00	2,521.00		>=0 / N/A / <0
AvP: OP FollowUp		40.00	34.00	18.00	62.00	-651.00	-1,669.00	-319.00	-228.57	-1,723.00	-750.00	2,213.00	7,136.00	6,943.00		>=0 / N/A / <0
AvP: Daycase Activity vs Plan	W	2	2	2	0	-78	-178	-100	-37	-267	-191	285	701	660		>=0 / N/A / <0
AvP: Outpatient Activity vs Plan	W	52	57	62	118	-1,741	-3,619	-1,281	-801	-3,214	-1,397	3,221	11,086	10,808		>=0 / N/A / <0
PDR	W	0.0%	1.1%	17.1%	24.7%	35.5%	57.8%	67.5%	67.6%	66.1%	66.1%	66.1%	0.1%	9.0%		No Threshold
Medical Appraisal	W	94.1%	94.1%	94.1%	94.1%	94.1%	94.1%	94.1%	96.8%	96.8%	96.8%	96.8%	24.0%	34.8%		No Threshold
Mandatory Training	W	88.5%	89.6%	89.1%	89.3%	88.0%	87.1%	84.8%	85.6%	86.7%	86.9%	87.8%	89.0%	87.1%		>=90 % / >=80 % / <80 %
Sickness	D	6.6%	5.6%	5.6%	5.9%	6.1%	6.8%	5.8%	6.2%	8.3%	6.5%	5.4%	5.2%	5.6%		<=4 % / <=4.5 % / >4.5 %
Short Term Sickness	D	1.5%	1.1%	1.4%	1.4%	1.7%	2.1%	1.2%	1.3%	3.2%	1.6%	1.5%	1.5%	1.7%		<=1 % / N/A / >1 %
Long Term Sickness	D	5.1%	4.6%	4.2%	4.5%	4.4%	4.8%	4.6%	4.9%	5.1%	5.0%	3.9%	3.7%	3.9%		<=3 % / N/A / >3 %
Temporary Spend ('000s)	D	322	204	310	332	286	446	505	415	434	382	560	518	459		No Threshold
Staff Turnover	D	9.8%	9.4%	9.6%	9.5%	9.4%	8.7%	8.3%	7.9%	8.2%	8.1%	7.8%	8.0%	9.8%		<=10 % / <=11 % / >11 %
Safer Staffing (Shift Fill Rate)	W		94.4%	86.8%	89.1%	93.6%	94.4%	95.3%	93.5%	89.6%	92.7%	93.7%	95.8%	99.2%		>=90 % / >=80 % / <90 %

Community & Mental Health Division

SAFE	**<u>Learning from Incidents:</u>** **Incident 49950** - Delay in starting the ALTE protocol. **<u>Learning</u>** - The importance of ensuring all parties involved with discussions about the ALTE protocol fully understand their individual role within the pathway. **Use of restrictive physical intervention** There was 1 restrictive intervention incident in May – restrictive intervention used to prevent young person injuring staff and damaging property.	**Highlight** • 115 incidents recorded in May – 87 Clinical and 28 non-clinical • Zero incidents resulting in moderate, semi-permanent, catastrophic harm or death • Zero never events • Zero pressure ulcers grade 3 or above • Reduction in medication errors in month from 17 to 9 **Challenges** • Access to manual handling training for staff and parents/carers remains a challenge
CARING	Briefing for staff provided at the Divisional Integrated Governance Committee on the new Complaints process and flow chart New video launched by the Camhelions 'You're Never Walking Alone' describing the positive solutions to mental health challenges young people have faced as a result of the pandemic.	**Highlight** • 20 Excellence Reports recorded • 20 compliments recorded in May • FFT scores for Outpatients stands at 94.4% **Challenges** • 49 PALs recorded in May 2021. Main theme relating to prescriptions and contacting Community Paediatrics/ASD/ADHD teams • 1 new formal complaint – joint complaint with Liverpool Locality Mental Health Services and Neurology relating to treatment for a tic disorder.
EFFECTIVE	Launch of the CYP One Mental Health referral platform, a one stop shop containing a single referral form covering a range of mental health services across Liverpool and Sefton.	**Highlight** • 755 calls received by the Crisis Care Service in May 2021 • Zero hospital cancellations with less than 6 weeks' notice • Reduction in outpatient appointments cancelled by the hospital to 8.5% **Challenges** • Continued increase in referrals for services in the Community & Mental Health Division, from 905 (April) to 1244 (May) • This includes a significant increase in referrals for Mental Health services, referrals in May 2021 were 54% higher than May 2019.
RESPONSIVE	Increase in RTT for Community Paediatrics to 74% in May 2021, with no children or young people waiting over 52 weeks.	**Highlight** • Continued reduction in pre-April 2020 ASD & ADHD cohort w • hich is expected to be completed as per plan

	Alder Hey confirmed as a 4 Week Wait pilot site, a government green paper objective to shape the potential introduction of access and waiting time standard for children and young people's mental health.	**Challenges** • 3 breaches of the urgent waiting time target for the Eating Disorders service and continued challenges with routine waiting times, due to significantly increased referrals and requirement for urgent appointments. A new staff member has been recruited and additional assessment appointments have been planned. • Significant increase in demand for ASD and ADHD services above predicted referral rates – 73% increase for ASD and 50% increase for ADHD.
WELL LED	BBC North West featured Alder Hey's Mental Health Services each night during Mental Health Awareness Week, highlighting the impact of the pandemic on the mental health of children and young people	**Highlight** • Mandatory training remains above Trust target at 91% • Sickness remains below Trust target at 3.8% • Staff turnover has decreased to 9.5% **Challenges** • PDR completion rate appears low at 1.5%, however actual completion rate is expected to be much higher. Support is being provided to line managers to ensure completion is recorded on ESR. • Challenges within the Trust recruitment team is impacting on delays with recruitment time.

Alder Hey Children's NHS Foundation Trust

Community

D Drive W Watch P Programme

SAFE

		May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss	D	6	6	8	5	8	16	10	16	5	5	9	8	12		No Threshold
Clinical Incidents resulting in No Harm	D	92	84	83	73	88	84	76	53	64	75	84	75	55		No Threshold
Clinical Incidents resulting in minor, non permanent harm	D	3	10	6	5	9	11	12	9	11	21	35	29	20		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm	D	0	0	0	0	0	0	0	0	0	0	0	0	0		No Threshold
Clinical Incidents resulting in severe, permanent harm	D	0	0	0	0	0	0	0	0	0	0	0	0	0		0 / N/A / >0
Clinical Incidents resulting in catastrophic, death	D	0	0	0	0	0	0	0	0	0	0	0	0	0		0 / N/A / >0
Medication Errors (Incidents)		7	6	11	10	20	33	26	16	19	17	23	17	9		No Threshold
Pressure Ulcers (Category 3)	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 / N/A / >0
Pressure Ulcers (Category 4)	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 / N/A / >0
Pressure Ulcers (Category 3 and above)		0	0	0	0	0	0	0	0	0	0	0	0	0		0 / N/A / >0
Cleanliness Scores			78.3%	100.0%		98.8%	98.8%					100.0%		99.0%		No Threshold
CCNS: Advanced Care Plan for children with life limiting condition		0														No Threshold
CCNS: Supported early discharges from hospital care		100.0%	100.0%													No Threshold
CCNS: Prescriptions		12	15													No Threshold

CARING

		May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Last 12 Months	RAG
Complaints	W	2	2	4	2	2	1	4	2	5	4	3	2	0		No Threshold
PALS	W	19	26	29	22	26	32	17	15	14	37	40	40	49		No Threshold

EFFECTIVE

		May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Last 12 Months	RAG
Referrals Received (Total)		465	620	876	635	856	978	1,049	848	775	878	1,099	905	1,265		No Threshold
Hospital Initiated Clinic Cancellations < 6 weeks notice		0	0	4	25	25	18	2	5	7	10	7	0	0		No Threshold
OP Appointments Cancelled by Hospital %		11.8%	6.3%	6.3%	10.5%	10.1%	10.0%	11.4%	8.2%	12.8%	9.7%	12.3%	11.5%	8.6%		<=5 % / <=10 % / >10 %
Was Not Brought Rate (New Appts)	W	10.2%	11.5%	10.6%	10.4%	6.9%	11.5%	8.2%	7.2%	9.5%	16.0%	18.1%	20.6%	28.2%		<=10 % / <=12 % / >12 %
Was Not Brought Rate (Followup Appts)	W	14.8%	14.5%	15.0%	13.6%	13.9%	13.3%	11.1%	12.9%	12.8%	12.9%	14.4%	18.6%	19.2%		<=14 % / <=16 % / >16 %
Was Not Brought Rate (New Appts) - Community Paediatrics		12.5%	11.5%	8.9%	12.0%	9.1%	14.6%	10.0%	9.1%	10.2%	23.1%	23.9%	29.4%	36.9%		<=10 % / <=12 % / >12 %
Was Not Brought Rate (Followup Appts) - Community Paediatrics		13.3%	11.6%	14.7%	14.1%	17.5%	14.9%	12.1%	14.7%	16.8%	19.0%	19.5%	27.9%	30.8%		<=14 % / <=16 % / >16 %
Was Not Brought Rate (CHOICE Appts) - CAMHS		22.4%	28.3%	25.7%	23.6%	9.7%	12.8%	13.3%	13.6%	19.7%	11.5%	15.1%	6.9%	16.3%		<=10 % / <=12 % / >12 %
Was Not Brought Rate (All Other Appts) - CAMHS		15.8%	16.1%	15.8%	13.9%	13.1%	13.3%	11.6%	13.2%	12.0%	10.9%	13.2%	14.1%	13.6%		<=14 % / <=16 % / >16 %
CAMHS: Tier 4 DJU % Bed Occupancy At Midday		91.2%	85.7%	87.6%	75.6%	91.4%	107.8%	91.0%	109.7%	110.1%	106.6%	114.3%	113.3%	114.3%		No Threshold
CAMHS: Tier 4 DJU Bed Days		386	360	380	328	384	470	382	478	476	420	496	478	496		No Threshold
Coding average comorbidities		3.00		2.00	6.00		4.50	3.33	3.00	3.00		4.00	9.00			No Threshold
CCNS: Number of commissioned packages		9	9													No Threshold

RESPONSIVE

		May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Last 12 Months	RAG
CAMHS: Tier 4 Admissions To DJU		1		1	1	1		2	2		1		1			No Threshold
CAMHS: Referrals Received		163	259	262	257	356	348	417	340	268	351	470	395	535		No Threshold

Alder Hey Children's NHS Foundation Trust

Community

D Drive W Watch P Programme

Measure	Type	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Last 12 Months	RAG
CAMHS: Referrals Accepted By The Service		93	144	154	146	268	193	232	198	158	182	252	198	256		No Threshold
CAMHS: % Referrals Accepted By The Service		57.1%	55.6%	58.8%	56.8%	75.3%	55.5%	55.6%	58.2%	59.0%	51.9%	53.6%	50.1%	47.9%		No Threshold
Convenience and Choice: Slot Availability		100.0%														>=96 % / N/A / <96 %
RTT: Open Pathway: % Waiting within 18 Weeks	W	42.5%	34.0%	32.3%	38.1%	40.2%	49.2%	64.3%	64.4%	66.2%	64.5%	66.0%	63.3%	74.0%		>=92 % / >=90 % / <90 %
Waiting List Size	W	1,013	1,184	1,032	1,109	1,051	795	756	800	785	911	911	828	765		No Threshold
Waiting Greater than 52 weeks - Incomplete Pathways	W	21	22	12	6	10	2	1	1	0	0	0	3	0		0 / N/A / >0
CAMHS: Crisis / Duty Call Activity		446	448	550	494	516	598	720	698	650	804	806	744	755		No Threshold
CAMHS: RTT (First Partnership) % waiting within 18 weeks	W	53.6%	49.3%	44.0%	53.2%	59.1%	68.8%	70.0%	69.9%	65.9%	67.9%	67.3%	65.6%	68.0%		>=92 % / >=90 % / <88 %
ASD: Completed Pathways		25	79	121	137	116	124	106	47	59	65	98	82	105		No Threshold
ASD: Completed Pathway Compliance (% within 18wks)		72.0%	54.4%	64.5%	74.5%	77.6%	93.5%	87.7%	85.1%	57.6%	84.6%	73.5%	28.0%	22.9%		>=92 % / >=90 % / <90 %
EDYS: Routine Completed Pathways per Month (Seen in 4 wks) (as 95%)	P			100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	91.7%	100.0%	46.2%	16.7%	23.5%		No Threshold
EDYS: Urgent Completed Pathways per Month (Seen in 1 wk) (as 95%)	P			100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	25.0%		>=95 % / >=92 % / <92 %
CCNS: Number of Referrals	W	134	149	188	122	144	146	151	127	119	139	169	120	135		No Threshold
CCNS: Number of Contacts	D	859	812	1,083	803	1,035	1,038	877	844	783	826	896	791	821		No Threshold

WELL LED

Measure	Type	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	W	-27	175	-26	0	-70	369	270	45	321	221	-41	14	212		No Threshold
Income In Month Variance (£'000s)	W	-64	139	-49	-44	96	397	155	75	148	996	150	94	88		No Threshold
Pay In Month Variance (£'000s)	W	131	-29	-64	-98	-31	-81	30	12	65	-81	137	5	-49		No Threshold
AvP: OP New		1.00	3.00	0.00	1.00	181.00	121.00	185.00	114.43	82.00	-48.00	127.00	532.00	665.00		>=0 / N/A / <0
AvP: OP FollowUp		10.00	13.00	4.00	14.00	679.00	657.00	902.00	1,057.48	677.00	899.00	1,221.00	3,644.00	3,716.00		>=0 / N/A / <0
AvP: Outpatient Activity vs Plan	W	11	16	4	15	850	774	1,086	1,170	761	850	1,348	4,177	4,381		>=0 / N/A / <0
PDR	W	2.1%	9.8%	16.6%	23.1%	41.3%	73.4%	81.9%	81.9%	83.1%	83.1%	83.1%	0.0%	1.5%		No Threshold
Medical Appraisal	W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	6.2%	24.0%		No Threshold
Mandatory Training	W	93.0%	92.8%	92.1%	92.0%	91.4%	91.7%	89.2%	88.4%	89.2%	88.6%	89.3%	91.8%	91.0%		>=90 % / >=80 % / <80 %
Sickness	D	3.5%	2.7%	2.5%	2.7%	3.8%	4.0%	4.3%	4.5%	5.7%	4.7%	3.9%	3.0%	3.8%		<=4 % / <=4.5 % / >4.5 %
Short Term Sickness	D	0.8%	0.5%	0.7%	0.9%	1.3%	1.6%	1.2%	0.9%	1.9%	1.0%	0.9%	0.8%	1.2%		<=1 % / N/A / >1 %
Long Term Sickness	D	2.7%	2.2%	1.8%	1.9%	2.5%	2.5%	3.2%	3.6%	3.8%	3.7%	2.9%	2.2%	2.6%		<=3 % / N/A / >3 %
Temporary Spend ('000s)	D	47	21	189	194	169	173	212	355	226	169	141	183	192		No Threshold
Staff Turnover	D	11.4%	11.4%	10.7%	10.6%	10.4%	9.7%	9.0%	8.7%	9.3%	9.5%	9.8%	10.6%	9.5%		<=10 % / <=11 % / >11 %
Safer Staffing (Shift Fill Rate)	W		96.2%	99.5%	99.8%	99.8%	100.1%	98.5%	98.6%	99.9%	99.4%	100.2%	97.2%	99.1%		>=90 % / >=80 % / <90 %

Research Division

SAFE	• Divisional Mandatory training demonstrates good compliance • Significant increase in number of incidents reported. This may be to change in culture and or pace of opening studies as part of recovery project. • All current risks compliant with review dates • CRF ICP (compliant) • All patients screened for potential COVID 19 prior to hospital visit using telephone triage • CRF will part of ward accreditation • Good uptake from Staff covid vaccine • All Areas have been certified Covid Secure • Perspex screening now in-situ allowing more desks to be released. • Phlebotomy samples (Healthy Control Samples) • CRD now in attendance at weekly meeting of harm	**Highlight** • Mandatory Training > 94% • GCP training 97% • SOP compliance 98% • ANTT compliance 100%-CRF Ward • CRD ICP compliant • Research continues with SIREN study • CRD involved in Trust Quality Rounds • X1 good catch reported with Siren Study **Challenges** • Trust PDR Target of 90% -aiming to achieve this year • Limited storage space on CRF causing H&S risk • Research blood samples for multiple trials • Delays with recruitment to children's vaccine study • 6 incidents reported (significant increase this month) • CRD report for SQUAC needs review
CARING	• 0 complaints received • Patient centred follow up care for patients on clinical trials • Patient feedback used to improve quality of patient care and experience • Plans underway to capture experience patient experience data • Recognition of outstanding care by Covid team for care delivered to patients under research opportunities	**Highlight** • X 0 Complaints • New Children's PRES developed for 21/22 ongoing • Staff survey results for CRD Division • Positive patient story for research celebrated via International Clinical Trials Day **Challenges** • More work to do on local patient internal audits • Low numbers of electronic survey questionnaires from patients on system
EFFECTIVE	• Studies stratified and selected based on best possible outcomes for children and young people. • Current portfolio regularly reviewed with monthly performance meetings • No housekeeping allocated to CRF ward. Nursing staff arranging and collection meals for patients. • Clinicians encourage children and young people to make informed decisions about participating in studies. • CRD performance reports and meetings restarted to review portfolio • Essential skills training approved for Division	**Highlight** • Project restart 80% NIHR CRN ambition achieved at 88% • Recovery of portfolio has gained momentum with significant increase in RTT numbers in April • Important Covid 19 studies remain open within Trust • Site selected for LAVA 2 study and recruited 10% of RTT despite IT challenges (Crit Care) • Siren Study has received NIHR certificate **Challenges** • CRF housekeeping • LAVA 2 study has struggled to gain recruits across the hospital. Discussions with PHE ongoing • Trust space for extension of Siren study • Diversity of portfolio studies to include Starting well • Staff Capacity to deliver partnership work with Innovation • Significant issues with recruitment process has delayed backfilling a number of vacancies affecting timely opening of new studies

RESPONSIVE	• All Staff Risk Assessments completed as required • New local systems and processes have been implemented to improve safety of staff, promote better team working to ensure safe staffing and cover for sickness, leave. • H&S Covid RA's completed for all areas of research • Coordinated and partnership working with local providers to offer joint training programmes. • AH prepared and awaiting green light from sponsor re Children's covid vaccine study	**Highlight** • Agile working implemented to reduce footfall • A.H supporting the wider system with Covid UPH activity • Collaborative working with external partners • Site selected for Adolescent covid vaccine study **Challenges** • Adolescent Vaccine study continues to be delayed at all sites • Reduced office space to accommodate increase in staff returning to site • Storage for site files and equipment is insufficient for research department
WELL LED	• PDR compliance remains at 87% • LTS absence rates have improved staff are supported through line managers and staff support. • Staff survey results for 2020 improved • Engagement with partners in relation to upcoming starting well initiatives.	**Highlight** • Division supporting staff with Flexible working (hybrid model) • Big Conversation event completed with action plan in place • CRD engaging staff with SALS • CRD above Trust target in all areas of staff survey • CRN 21/22 forecast stable in Q1 **Challenges** • Service Re-organisation planned • LTS numbers increased • Correct model for the future working to be established • Reduction in CRN funding for 21/22 challenged • CRD overall financial deficit to be reduced following recovery from pandemic

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

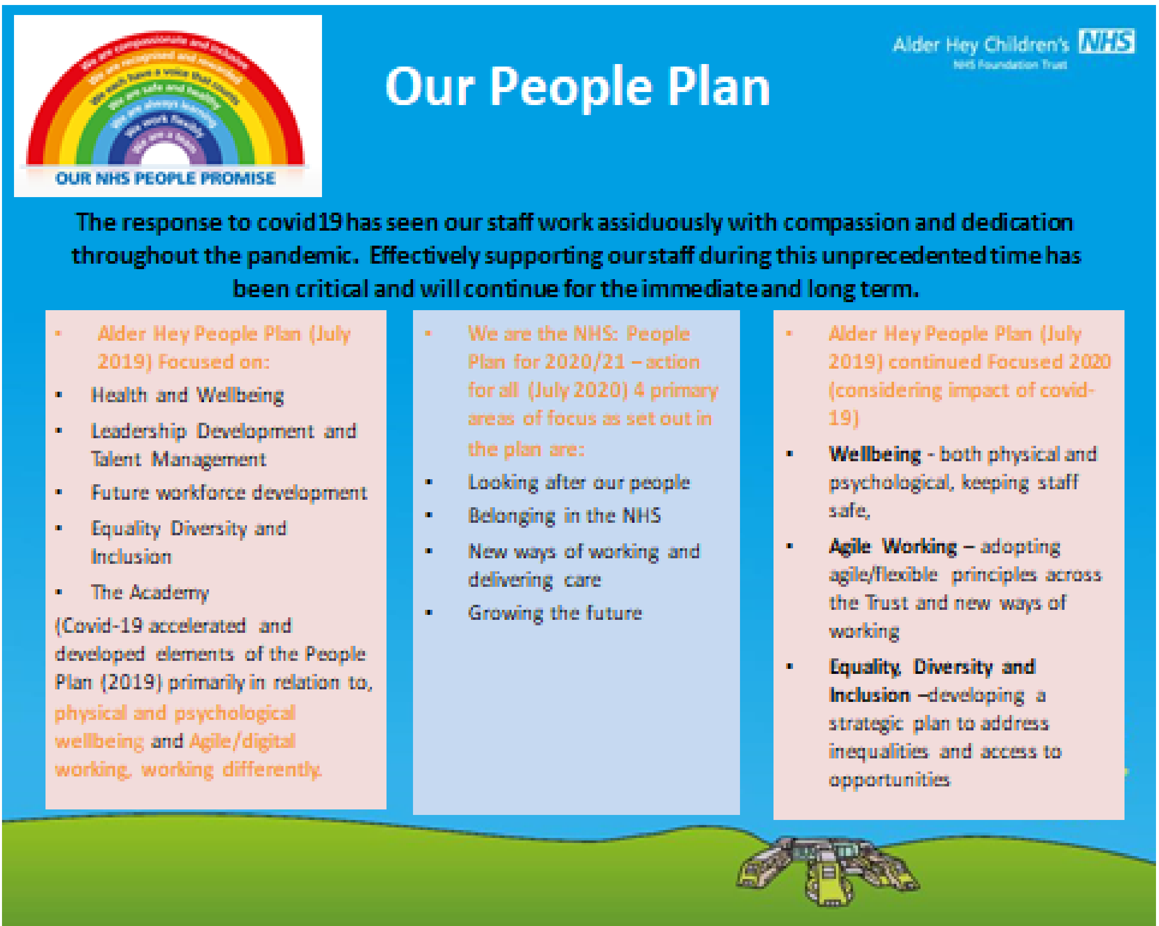
Thursday 24th June 2021

Paper Title:	**People and Wellbeing update**
Report of:	**HR and OD Department**
Paper Prepared by:	Director of HR & OD

Purpose of Paper:	Decision Assurance Information Regulation	☐ ■ ■ ☐
Background Papers and/or supporting information:	None	
Action/Decision Required:	To note To approve	■ ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** **The best people** doing their best work Sustainability through **external partnerships** Game-changing **research and innovation** **Strong Foundations**	☐ ■ ☐ ☐ ■
Resource Impact:		
Associated risk (s)	1739; 2100; 2157; 2160; 2161; 2181	

1. Purpose

The purpose of this paper is to provide the Board with a strategic update on the Alder Hey People Plan and our response to the requirements of the national NHS People Promise.



2. Wellbeing

2.1 Staff Advice and Liaison

The Staff Advice and Liaison service has continued to remain busy, with activity increasing through June. To date SALS have had over 1500 contacts to the service. Whilst very busy, the team are still able to respond quickly (within 24 hours) to any new referral which comes via e mail, phone call or drop in. The main themes that staff are presenting with:

- Trauma
- Staff in Crisis (some presenting with suicidal ideation)
- Anxiety
- Burnout
- Workplace Issues
- Relationship issues within workplace
- Isolation due to COVID and lockdown
- Bereavement
- Supporting staff on Long Term sick and facilitating a return to work and often undertaking Stress Risk Assessments
- Supporting staff through formal employment processes
- Domestic Abuse

Specific focus has been given by the team over the past month to the ED team including drop-ins in ED, virtual drop ins for consultants and senior leadership, support to access Wingman on Wheels and other physical wellbeing support. The team are continuing to meet with the Divisional Director of Medicine to ensure that a robust support plan is in place and fit for purpose given presenting needs of the staff in ED.

The service is also offering SALS @ sessions and have recently undertaken a joint SALS/IT session down in facilities which was received positively and are planning some SALS @ sessions out in the community.

Over the last two months the team are also receiving increased requests to support teams across the organisation in the following ways:

- Debriefing following traumatic clinical incidents
- Reflective sessions to make sense of the impact of Covid on team functioning
- Listening events for more vulnerable groups of staff
- Debriefing on the wards for teams to process the impact of Covid

In addition to working with individuals and teams, the SALS team are also working on early intervention and prevention activities around burnout (including developing burnout live event and information), menopause, and focussed early intervention work with facilities (including a joint SALS/IT drop in in facilities on 17th June).

The team are also busy linking with regional and national health and wellbeing networks and are attending the Cheshire and Merseyside Partnership People Summit in June to present '*Flourishing in adversity; A showcase of staff engagement at Alder Hey'.* There are also plans to deliver a webinar and podcast via NHS Employers and we have been invited to open the NHS Employers conference in December this year.

2.2 Recovery

The Recovery task force has been busy and active over the past 2 ½ months, meeting weekly to develop an action plan based on the three key principles of rest, connect and share. Data from our recovery survey has supported this plan and also highlighted the areas where staff feel they most need support, including support to rest and take annual leave, increased flexible working arrangements and reflective spaces to process the events of the past year.

Actions taken include 2 wellbeing days given to all staff by the organisation, a series of listening events developed (with early focus on operational teams and staff with disabilities), a programme of social events developed to enable staff to safely connect with each other, a "rest kit" in development to enable staff to switch off (with a focus on surviving our "always on" world) and to provide guidance on running reflective team sessions and a plan for whole organisation debriefing and learning. There is also now a 12 month programme of whole organisation Schwartz Rounds planned reflecting themes arising from the organisation, with the latest Round being on the theme of Hope. In addition, 30 additional staff (predominantly nurses and AHPs) will be trained later this year to be Schwartz facilitators to support the roll out of Team Time across the organisation.

The Recovery task force has now finished and a smaller Wellbeing Action Group established (comprising SALS, Wellbeing Guardian and comms) to continue to monitor actions and integrate with other developments including embedding the Wellbeing Guardian role. This group will feedback to the Wellbeing Steering Group.

As part of the Recovery plan, there will be a monthly Ground TRUTH slot at the Executive meeting to feedback information gathered through the variety of listening events and means (including recovery survey, Ground TRUTH tool, listening events with redeployed theatres staff/operational teams/staff with disabilities) agree actions, and communicate with the organisation in an iterative process. The first session will be on the 24th June.

2.3 Health Wellbeing Steering Group

Attendance at the Health and Wellbeing Steering Group remains good with representation across Divisions and Corporate areas and the steering group meets once a month. The current focus of the health and Wellbeing steering group, are:

- Financial wellbeing
- Staff Survey and the Big Conversations
- Health and Wellbeing conversations
- Menopause support

2.4 Health and Wellbeing conversations

As per NHSE guidance the Trust has now rolled out Health and Wellbeing conversations which are being offered to all staff in the organisation. Combined in the first instance with the PDR discussions, these are to be booked in and planned as part of the PDR. Options are available for staff to have their Health and Wellbeing Conversation with someone other than their manager if this feels more appropriate for them, via our Wellbeing Coaches. The SALS manager attends the PDR training sessions to delivery Health and Wellbeing Conversation Training and additional resources are available for those staff who want to find it on the intranet. Feedback on the rollout of the conversations is important to us so we are regularly asking our colleagues to feedback on these conversations. To date this feedback has been positive.

As per guidance these are personal conversations with line managers and are not recorded, however we do ask that if staff identify that they have caring responsibilities they are asked for permission for us to record that with HR which will help us going forward when we are looking at rollout of the Carers Passport. We are recording that everybody who has been offered a PDR would also be offered a Health and Wellbeing Conversation.

3. Equality, Diversity & Inclusion

The Trust Black, Asian and Minority Inclusion Taskforce led by Claire Dove OBE, continues to meet monthly to focus on improving and championing positive people practises within the organisation.

Amongst other activities, three key workstreams have been identified to date focusing on recruitment, apprenticeships and zero tolerance with task and finish groups established with representatives from across the Trust working collaboratively. A full and comprehensive action plan is in place and progress monitored against plan is reported monthly to the Taskforce.

4. Flexible Working

The Trust continues with its roll-out of hybrid working; a policy framework in in development with staff side colleagues, and training and awareness sessions will be held with managers in July to support the management of hybrid teams.

5. Staff Availability

Table 1- Sickness position as of 14th June 2021

Reason	Trust	
	%	No of Staff
Non Covid Related Sickness	4.81%	191
Covid Related Sickness	0.18%	7
Absence Related to Covid - not inc sickness	0.28%	11
Absence Related to Covid Inc Sickness	0.345%	18
All Absence (total of above)	5.26%	209

During the first half of June, we have seen a very small increase in COVID related illness, both in self isolation and staff who are symptomatic, reflective of the increasing rate of infections in the North West. Staff have been reminded to be vigilant and we will continue to follow all safety measures across the organisation. Absence will be monitored closely for any emerging trends/hotspots.

6. Governance and Ongoing Business

6.1 Case Management

In line with the national Social Partnership Forum (SPF) all cases continue to be managed on a case-by-case basis in partnership with staff side colleagues from all of our recognised Unions with appropriate measures and risk assessments put in place to ensure staff health and wellbeing continue to be prioritised.

In June 2021 there are 25 cases currently ongoing. This is an increase of 6 since May; these consist of two new Early Conciliation contacts from ACAS, and an increase in three Stage 3 sickness absence processes.

Table 1- Employee Relations Activity Per Division as of 17th June 2021

Division	MHPS	Disciplinary	Grievance	B&H	Appeal	ET	Stage 3	Total
Surgery (1326 staff)	2	4	4	1	2	2	5	**20**
Medicine (1223 staff)	1	1	0	0	0	0	0	**2**
Community (687 staff)	1	1	0	0	1	0	0	**3**
Corporate & Research (695/65 staff)	0	0	0	0	0	0	0	**0**
Grand Total	**4**	**6**	**4**	**1**	**3**	**2**	**5**	**25**

6.2 Training

As of the 10th June 2021, Mandatory Training was at 88% overall, 2% below the Trust target of 90%, this is the same as May but we have seen a consistent improvement over the last 5 months since the height of the second wave. We continue to work with staff and managers to ensure training compliance is up to date via our monthly reporting to divisions and departments and through directly contacting staff who are not 100% compliant.

Our key areas of focus continue be annual resuscitation training (BLS & PLS/APLS Update) and our Estates and Ancillary staff.

This month we have seen our Estates and Ancillary staff group compliance increase by a further 6% (up 15% over the last two months) and are working with our subject matter experts to continue to identify ways we can support this staff group in particular to improve compliance as they find it more difficult to utilise the e-Learning offerings available than some other staff groups. Some of the ways we are addressing this include bespoke recorded sessions and support for managers to facilitate topics as well as socially distanced bespoke face to face sessions for staff delivered by our subject matter experts.

We continue to utilise remote/e-learning for training delivery where possible to encourage social distancing and ensure the safety of staff whilst regularly reviewing current Trust guidance around face to face delivery so we can begin to offer some socially distanced face to face training in the future as required.

Table 3- Mandatory Training compliance 17th June 2021

Division	Overall Mandatory Training	Change (Since last report)
Trust	87.98%	-0.10%
Division	**Overall Mandatory Training**	**Change (Since last report)**
411 Alder Hey in the Park	84.68%	8.74%
411 Community	92.22%	0.49%
411 Corporate Other Department	86.85%	0.00%
411 Facilities	65.25%	5.45%
411 Finance	88.36%	0.16%
411 Human Resources	90.29%	1.48%
411 IM&T	94.15%	-0.22%
411 Innovation	97.06%	19.61%
411 Medicine	88.02%	-0.73%
411 Nursing & Quality	90.99%	1.22%
411 Research & Development	96.30%	0.14%
411 Surgery	87.70%	-0.87%

Board of Directors

Thursday 24th June 2021

Report of	Development Director
Paper prepared by	Associate Development Director- (17/06/2021) Russell Gates
Subject/Title	Development Directorate Campus Development report on the Programme for Delivery
Background papers	Nil
Purpose of Paper	The purpose of this report is to update the Trust Board on the Campus delivery.
Action/Decision required	The Board is asked to acknowledge the content of the report, the current status, risks and actions.
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	➢ Delivery of outstanding care ➢ Sustainability through external partnerships
Resource Impact	Capital projects budget.

Campus Development report on the Programme for Delivery

June 2021

1. Introduction

The purpose of this report is to keep the Board informed of progress, risks and actions on the key capital projects as they arise.

As of Month 3 in Quarter 1 of 2021/22 the programme Delivery Timetable RAG rates projects against planned commencement date.

2. Programme Delivery Timetable

Table1. Sets out the planned programme for the years 2019-2023 (financial years).

Table 1.	**19/20**	**20/21**				**21/22**				**22/23**
Scheme	**Qtr. 4**	**Qtr.1**	**Qtr.2**	**Qtr.3**	**Qtr.4**	**Qtr.1**	**Qtr.2**	**Qtr.3**	**Qtr.4**	**Year**
Initial Park Reinstatement (Phase 1) **COMPLETE**										
Alder Centre occupation **COMPLETE**										
Acquired buildings occupation Future use under review										
Police station (Lower Floor) occupation										
Commence relocations from retained estate.							*		Final phase	
Decommission & Demolition Phase 3 (Oncology, boiler house, old blocks)										Final phase
Main Park Reinstatement (Phase 2/90%)										
Mini Master plan (Eaton Rd Frontage) 2 phases to plan										
Infrastructure works & commissioning										
Catkin Centre Construction										
Catkin Centre Occupation										
Sunflower House Construction										
Sunflower House Occupation										
Demolition Phase 4 (Final)										
Final Park Reinstatement (Phase 3)										
Neonatal Development Tendering and Design										
Neonatal Construction										
Neonatal Occupation										

3. Project updates

Park Reinstatement Phase 1

Current status	Risks & Issues	Actions/next steps
The new grass and shrubs continue to flourish and the mixture of sunshine and rain has supported this. The handover to the council is still under discussion and the Trust is awaiting a date from the council for the formal handover. The team is working with the Council to formalise the handover as quickly as possible so that the park can be used by the public. The formation of the Multi-Use Games Area (MUGA) is still in delay and materials are currently in storage for when a decision is reached. The planning application for siting the MUGA will be made in the next 2-3 weeks. Work continues by Capacity Lab and the local community in the setting up of a Charitable Benefit Organisation. Members of the Friends and Community of Springfield parks groups have had an opportunity to walk the development over the last month.	Location of Multi-Use Games Area (MUGA). (Risk 2348, risk rating 9) Public perception that the park phase one is not being delivered.	Continued meetings with planners, residents and LCC parks officers to resolve the location. Capacity lab continues to engage with groundworks on a regular basis and involve stakeholders.

Acquired Buildings Occupation (neighbouring sites)

Current Status- on hold	Risks/issues	Action/next steps
Knotty Ash Nursing Home **Under review following fire on 10th May.**	Delays to insurance pay out delays rebuild	Extent of fire damage being assessed by Loss Adjusters. Awaiting direction

		on full re-build or partial reinstatement/rebuild

Police Station (lower floor) occupation

Current status- no update since last report	Risks/issues	Actions/next steps
The Police have recently postponed any discussion about the Trust taking space in their building as they intend to use it themselves over the Covid crisis. It is unclear at present how long this postponement is likely to last but its anticipated this will not move forward until the Cluster is complete and the Police occupy the new build. *This has now been escalated to see if a vacation date this year can be achieved.*	Police do not release the space while decisions are made in regard to additional police funding and its use. (Risk 2088, risk rating 12)	Development team agreed a contingency plan which has been actioned on a temporary basis. A long-term plan is now required and will be formed as part of the work on relocation of staff.

Relocations

Current status	Risks/issues	Actions
The Trust made a decision to lease 1000m2 of space at Innovation Park (IP) which will accommodate a number of corporate departments. The lease is now signed and design and tendering of the new space is underway. The date for occupation is expected to be the end of August/early September. Weekly meetings with departmental leads and team representatives continue and feedback is mostly positive. A space steering group has been formed and is chaired by the Director of HR and OD into which this development feeds.	Timely relocation and redirection of services are delayed (2104 risk rating 9 and 2105 risk rating 12)	Work with the landlord and furniture suppliers to implement design and procure furniture in accordance with e programme.

Demolition Phase 3 (Oncology, boiler house, old blocks)

Current status	Risks/issues	Actions
The boiler house, water tower and management block are now demolished. The old estates workshops are now being demolished.	Asbestos removal cost/time	Complete the required works to make the land safe. Work with Finance colleagues to find the additional financial commitment and reduce the financial risk.

Park reinstatement Phase 2/3

Current status	Risks/issues	Actions
The new formation levels continue ready for the landscaping to follow in late July/early August subject to the approval of the revised costs which will be presented to RABD in July. Learning from phase 1, the programme now allows for completion ready for seeding in the spring growing season to avoid delays through the winter. Capacity Lab have two major parties interested is supporting enhancement to the park through provision of a café/changing area. Heritage Lottery Fund application has been made to secure funds for a heritage trail around the park with the possibility of an exhibition area related to the old hospital.	Funding required is not delivered through the partnership approach. (relates to risk 1241 , score 16) Budget for Phases 2 & 3 is inadequate.	Working with landscape designer to reduce costs within the parameters of the Land Exchange Agreement. Capacity lab continues to hold regular discussion with LCC and also keep the local community up to date with progress. Share the design and costs with interested parties in view they could agree to fund the development.

NEW Mini Master Plan for Eaton Rd frontage

Current status-	Risks/issues	Actions
Status unchanged Turkington Martin, have been engaged for the initial design which will take in the Blue Light Road, the landscape surrounding the new Builds (Institute, Alder Centre and Cluster). Work on the design continues, with involvement of the Arts group. Although the design of a substantial part of the landscaping is complete, there are areas related to swales and the attenuation pond in the infrastructure works that are not complete and are required for the final designs. This is not an issue as the implementation is not yet required.	If not planned appropriately is could cause traffic congestion in the future. (Risk 2354, risk rating 8)	Continue design work incorporating advise on traffic management from Curtins. Confirm total costs and identify any gaps in the allocated budget.

Infrastructure works & commissioning

Current status	Risks/issues	Actions
The programme for the new infrastructure is progressing in line with the overall delivery programme for the campus developments. The implementation of the new infrastructure continues to programme but remains a concern as there is no float. The key elements of the electrical infrastructure work have been absorbed into the Sunflower House construction contract to avoid clashes of 2 contractors on the same site.	Early indication is that to complete all of the work will exceed budget. Awaiting tenders to confirm. Must maintain programme to avoid delays to the cluster and neonates projects	Value engineer the proposed plans with the architect. Explore estimated costs and market test/tender. Monitor the programme interfaces between projects.

Catkin Centre and Sunflower House Construction

Current status	Risks/issues	Actions
Contract with Galliford Try remains on programme with good visible progress. Planning of the occupational commissioning is well underway with representation of the users, clinical staff, FM and estates. Changes to the roof specification to meet insurance requirements and changes to the police accommodation are putting the budget under pressure. Savings are being sought from other project budgets.	Ongoing design development potentially could raise issues of quality leading to increases on cost. Late change leads to delays and additional costs. Budget for furniture is inadequate	Continue with weekly meetings with Galliford Try and challenge design where necessary. Costed schedules to be produced to ensure affordability..

Demolition Phase 4 (Final)

Current status	Risks/issues	Actions
N/A at current time, planned for Qtr. 4. 21/22	Cost may exceed current allocated budget.	Monitor demolition budget management on a monthly basis and work up contingency plan.

Neonatal Development

Current status	Risks/issues	Actions
RABD approved the issue of the tender to contractors in May 2021 and this has now been issued. The approval of the PAU business case and changes to the cladding colour could delay the start of the phase 4 design and planning by up to 2 months. Negotiation of the Deed of Variation (DoV) is almost complete and the flow down to the building contract has been done with a draft building contract issued with the tender package. Tenders are due back in early August.	Project Co engagement extending the programme and increasing costs. Planning and any unknown Section.106 or section S.278 costs	Continue working with Project Co to mitigate impact. Work with LCC planners to minimise impact

Three parties interested in the construction Tilbury Douglas (formerly known as Interserve), Morgan Sindall and Galliford Try	Planning permission fails to be achieved within the timescale of the overall programme delivery.	Maintain open communication with the LCC planning departments.

North East Plot Development

Current status- static	Risks/ Issues	Actions/next steps
StepPlaces, the Developer who has purchased the north east plot of land, is currently in discussion with the trust on how the development could support. StepPlaces planning application decision has been postponed to a July committee.	Change process with Staff will present some challenges	Maximise our offering/ support /negotiation on development content and opportunities. Work through each work stream and provide a business case for each to demonstrate requirements, sustainability and affordability. Produce robust business cases to highlight any issues/risks. Ensure Colleagues from HR are involved in any proposed changes along with all stakeholders.

Communications

Current status-	Risks / issues	Actions/next steps
Regular dialogue between development team and Communications department are now in place to cover the park development. Fortnightly meetings established to discuss wider campus development progress.	Loss of reputation, locally and regionally.	Maintain links with community and support their development work.

	Lack of engagement internally and externally	

Car Parking

Current status	Risks/Issues	Actions/next steps
Status unchanged The Trust has now opened the Thomas Lane car park which is being leased from Liverpool City Council. The car park provides 134 spaces and will be open from 6am-6pm Monday to Friday. A new member of staff is being sought commence work on how we can implement a green travel plan.	Staff resistance to change. Travel plan from Mott MacDonald does not provide realistic and evidenced solution.	Review car parking requirements in view of the home working and off site office building. Car parking group to continue to work with Mott MacDonald and internal group members to produce an overall green travel plan.

4. Trust Board of Directors

The Trust Board of Directors is requested to receive and acknowledge the update provided as of 21st May 2021.

BOARD OF DIRECTORS

Thursday 24th June 2021

Paper Title:	**Board Assurance Framework 2020/21 (May)**
Report of:	Erica Saunders, Director of Corporate Affairs
Paper Prepared by:	Executive Team and Governance Manager

Purpose of Paper:	Decision Assurance Information Regulation	☐ ■ ☐ ☐
Background Papers and/or supporting information:	Monthly BAF Reports	
Action/Decision Required:	To note To approve	■ ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** **The best people** doing their best work Sustainability through **external partnerships** Game-changing **research and innovation** **Strong Foundations**	■ ■ ■ ■ ■
Resource Impact:	Non achievement of the Trust's objectives could have a negative impact on the services provided by the Trust.	

Board Assurance Framework 2020/21

1. Purpose

This report is a summary of the current Board Assurance Framework (BAF) for review and discussion. The purpose of the report is to provide the Board with assurance on how strategic risks that threaten the achievement of the trust's strategic plans and long term objectives are being proactively managed, in accordance with the agreed risk appetite. The BAF for Alder Hey Children's Foundation Trust currently consists of a set of 12 principal risks aligned to the Trust's strategic objectives.

A properly used BAF will drive the agendas for the Board and its Committees.
The board assurance committees therefore review the BAF in advance of its presentation to the Trust Board and propose any further changes following Exec Lead monthly reviews to ensure that it remains current, that the appropriate strategic risks are captured and that the planned actions and controls are sufficient to mitigate the risks being identified.
The newly formed Care Delivery Board (monthly Risk Management Meeting) is responsible for the Corporate Risk Register and for oversight of the Divisional Risk Registers and reports into the Audit and Risk Committee.

2. Review of the BAF

Strategic risks can often span across more than one area of accountability. The Board Committees are therefore provided with the whole BAF in case they need to refer to areas of potential overlap or duplication with other BAF Risks ensuring a holistic joined-up approach. Responsibility to review and gain assurance to controls and any required actions are detailed below:

	BAF Risk	Reviewed By
1.1	Inability to deliver safe and high quality services	Safety & Quality Assurance Committee
1.2	Inability to deliver accessible services to patients, in line with national standards, due to the adverse impact of COVID-19 on waiting times for elective care	Safety & Quality Assurance Committee
2.1	Workforce Sustainability and Development	People & Wellbeing Committee
2.2	Employee Wellbeing	People & Wellbeing Committee
2.3	Workforce Equality, Diversity & Inclusion	People & Wellbeing Committee
3.1	Failure to fully realise the Trust's Vision for the Park	Resources and Business Development Committee
3.2	Risk of failure to deliver 'Our Plan' objectives to develop a healthier future for Children through leadership of 'Starting Well' and Women and Children's system partnerships	Resources and Business Development Committee
3.4	Financial Environment	Resources and Business Development Committee
4.2	Digital Strategic Development and Delivery	Resources and Business Development Committee
4.1	Failure to deliver against the trust strategy and deliver game changing Research and Innovation that has a positive impact for Children and Young People.	Innovation Committee
1.3	Keeping children, young people, families and staff safe during	Trust Board

	COVID-19	

3. Overview at 15th June 2021

The diagram below gives a high level heliview of the current version, followed by a summary and a brief on the changes since the last Board meeting.

BAF Risk Register - Overview at 15 June 2021
1.2: Inability to deliver accessible services to patients, in line with national standards, due to the adverse impact of COVI (S)
3.4: Financial Environment (S)
2.3: Workforce Equality, Diversity & Inclusion (S)
3.2: Failure to deliver 'Our Plan' objectives to develop a Healthier Future for Children & Young People through leadership of (S)
1.3: Keeping children, young people, families and staff safe during the COVID-19 pandemic (S)
3.1: Failure to fully realise the Trust's Vision for the Park (S)   1.1: Inability to deliver safe and high quality services (S)
2.1: Workforce Sustainability and Development (S)
4.1: Failure to deliver against the trust strategy and deliver game changing Research and Innovation that has positive impact (S)
2.2: Employee Wellbeing (S)
4.2: Digital Strategic Development & Delivery (S)

Trend of risk rating indicated by: NEW, B - Better, S - Static, W – Worse
Report generated by Ulysses

Corporate risks are linked to BAF Risks – a summary of these risks can be found at appendix A. The full BAF document is included as Appendix B which reflects the active review of risks, any changes to risk ratings, progress against existing actions, gaps in controls and review of the adequacy of mitigations.

4. Summary of BAF - at 15th June 2021

The diagram below shows that all risks remained static in-month.

Ref, Owner	Risk Title	Board Cttee	Risk Rating: I x L		Monthly Trend	
			Current	Target	Last	Now
STRATEGIC PILLAR: Delivery of Outstanding Care						
1.1 NA	**Inability to deliver safe and high quality services**	SQAC	3x3	2x2	STATIC	STATIC
1.2 AB	**Inability to deliver accessible services to patients, in line with national standards, due to the adverse impact of COVID-19 on waiting times for elective care**	SQAC	4x5	3x2	STATIC	STATIC
1.3 JG	**Keeping children, young people, families and staff safe during COVID-19**	Trust Board	4x3	3x3	STATIC	STATIC
STRATEGIC PILLAR: The Best People Doing Their Best Work						
2.1 MS	**Workforce Sustainability and Development**	PAWC	3x3	3x2	STATIC	STATIC
2.2 MS	**Employee Wellbeing**	PAWC	3x3	3x2	STATIC	STATIC
2.3 MS	**Workforce Equality, Diversity & Inclusion**	PAWC	4x3	3x2	STATIC	STATIC
STRATEGIC PILLAR: Sustainability Through External Partnerships						
3.1 DP	**Failure to fully realise the Trust's Vision for the Park**	RABD	3x3	3x2	STATIC	STATIC
3.2 DJ	**Risk of failure to deliver 'Our Plan' objectives to develop a healthier future for Children through leadership of 'Starting Well' and Women and Children's system partnerships**	RABD	4x3	4x2	STATIC	STATIC
3.4 JG	**Financial Environment**	RABD	4x4	4x3	STATIC	STATIC
STRATEGIC PILLAR: Game-Changing Research And Innovation						
4.1 CL	**Research and Innovation activities could result in reputational downside or contract risk**	Innov.	3x3	3x2	STATIC	STATIC
4.2 KW	**Digital Strategic Development and Delivery**	RABD	4x1	4x1	STATIC	STATIC

5. Summary of May updates:

External risks

- ***Risk of failure to deliver 'Our Plan' objectives to develop a healthier future for Children through leadership of 'Starting Well' and Women and Children's system partnerships (DJ)***
  Risk reviewed; no change to score in month. Progressing implementation of C&M CYP programme. System-wide RSV surge plan under finalisation.

- ***Workforce Equality, Diversity & Inclusion (MS)***
  Actions progressing against plan - EDI post interviews taking place 8th June 2021

Internal risks:

- ***Inability to deliver accessible services to patients, in line with national standards, due to the adverse impact of COVID-19 on waiting times for elective care (AB)***
  There has been a reduction in the number of children waiting over 52 weeks for treatment from 283 in April to 230 in May. This improvement has been driven by high levels of recovery in outpatients (113%) and elective care (107%). The national accelerator programme will provide additional capacity through investment in equipment and staffing levels and additional sessions. We expect an additional 4,000 patients to receive treatment through this programme. There is a threat to elective capacity in Q3 and Q4 as an RSV epidemic would see a surge in attendances and hospitalisations that would put pressure on hospital capacity and contract elective care.

- ***Keeping children, young people, families and staff safe during COVID-19 (JG)***
  Recovery continues to progress well. Continual focus on latest IPC guidance and impact on our environment. Focus ahead of the summer on a Summer/Winter Plan which is captured in BAF action 1.2.

- ***Inability to deliver safe and high quality services (NA)***
  Risk reviewed and all actions remain current. Risk to be reviewed next month

- ***Financial Environment (JG)***
  Risk reviewed and actions updated to reflect latest position.

- ***Failure to fully realise the Trust's Vision for the Park (DP)***
  Review prior to June Board

- ***Digital Strategic Development and Delivery (KW)***
  BAF reviewed, good progress against actions.

- ***Workforce Sustainability and Development (MS)***
  Action plans progressing. Workforce planning methodology needs to be revisited.

- ***Employee Wellbeing (MS)***
  Risk reviewed. Actions updated to reflect increase in risk to staff in ED and support plan developed to mitigate this risk and offer enhanced support to ED staff.

- ***Failure to deliver against the Trust's strategy and deliver game changing Research and Innovation that has positive impact for Children and Young People (CL).***
  JUNE 21 - Risk review and updated for data risks.

Erica Saunders
Director of Corporate Affairs

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Appendix A

Links between BAF and high scored risks – as at 15th June 2021

BAF Risk | **Strategic Aim** | **Related Corporate Risk**

Strategic Aim: Delivery of **outstanding care**

1.1 Inability to deliver safe and high quality services

Related Corporate Risk 1.1:

(2183) Staff, patients and the public will not be able socially distance whilst waiting in ED.

(2233) Failure to meet QST Major Trauma peer review standards.

(2235) There is a risk that patients will not get an outpatient appointment within the clinically appropriate timescale because of the poor data quality of our current outpatient waiting list.

(2265) Children and young people on the waiting list experience an avoidable delay to care

(2312) Patients are not adequately managed from a medical perspective (paediatric medicine /neonatology) whilst under the care of Neurosurgery and Craniofacial

(2315) Overprescribing (10 times) of medication

(2332) Inadequate provision of service delivery if agreement cannot be reached by two main providers of paediatric cardiology care over how best to provide a 'joint approach' to service provision.

(2377) Incomplete record of patient's treatment, patient could be given the incorrect treatment.

(2384) Infection Control Risk – Risk of infection from spores to the children post op cardiac surgery.

(2410) : Limited access to primary care and community based services for patients, which results in attendance to the Emergency Department. This means that we are unable to deliver the standard of care to our patients that is required.

(2414) New referrals not being triaged timely, non-complaint with RTT pathway. Follow up patients not receiving appointments in detailed time frame, cohorts being lost to follow up due to lack of oversite. Patients not able to receive Laser treatment due to lack of training and knowledge of current team. Patients not able to receive Laser treatment timely due to availability and capacity of current team. Changed from Divisional level on the 19.5.21.

(2383) Psychology provision not meeting minimal NHSE Standards. Currently only able to focus on more severe presentations or crisis management for patients. Risk of negative impact on the mental health of patients by not being able to provide timely care to avoid exacerbation or progression of presentation.

(1560) New patients referred to CAMHS Liverpool may breach 18 week referral to treatment target.

(2434) Failure to meet the 90% target compliance for Trust wide Resuscitation Training in line with Mandatory Training Policy - E21.

(2230) Ten-fold medication errors resulting in serious harm to patients.

(2436) Significant reduction in the service provision. No 3D photography service, limited on-call service, limited appointments available

1.2 Inability to deliver accessible services to patients, in line with national standards, due to the adverse impact of COVID-*19* on waiting times for elective care

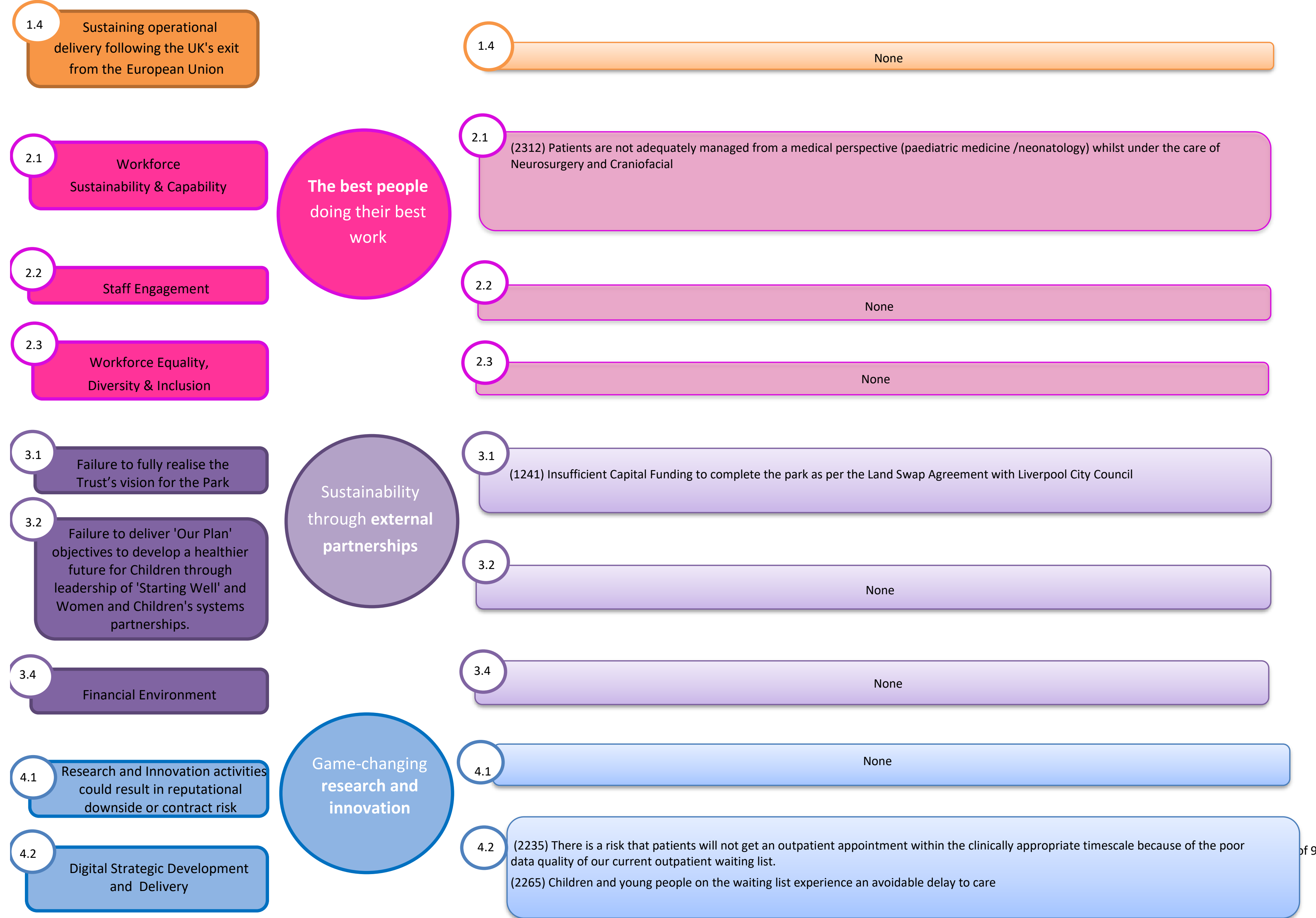
Related Corporate Risk 1.2:

(2233) Failure to meet QST Major Trauma peer review standards.

1.3 Keeping children, young people, families and staff safe during COVID-19

Related Corporate Risk 1.3:

None


1.4
Sustaining operational delivery following the UK's exit from the European Union
2.1
Workforce Sustainability & Capability
2.2
Staff Engagement
2.3
Workforce Equality, Diversity & Inclusion
The best people doing their best work
3.1
Failure to fully realise the Trust's vision for the Park
3.2
Failure to deliver 'Our Plan' objectives to develop a healthier future for Children through leadership of 'Starting Well' and Women and Children's systems partnerships.
3.4
Financial Environment
Sustainability through external partnerships
4.1
Research and Innovation activities could result in reputational downside or contract risk
4.2
Digital Strategic Development and Delivery
Game-changing research and innovation
1.4
None
2.1
(2312) Patients are not adequately managed from a medical perspective (paediatric medicine /neonatology) whilst under the care of Neurosurgery and Craniofacial
2.2
None
2.3
None
3.1
(1241) Insufficient Capital Funding to complete the park as per the Land Swap Agreement with Liverpool City Council
3.2
None
3.4
None
4.1
None
4.2
(2235) There is a risk that patients will not get an outpatient appointment within the clinically appropriate timescale because of the poor data quality of our current outpatient waiting list.
(2265) Children and young people on the waiting list experience an avoidable delay to care
of 9

Board Assurance Framework 2021-22

BAF 1.1	Strategic Objective: Delivery Of Outstanding Care		Risk Title: Inability to deliver safe and high quality services		
Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led			Link to Corporate risk/s: 2265, 2312, 2235, 2355, 2377, 2315, 2233, 2242, 2183, 2310, 2332		
Exec Lead: Nathan Askew		Type: Internal, Known	Current IxL: 3x3	Target IxL: 2x2	Trend: STATIC

Assurance Committee: Safety & Quality Assurance Commitee

Risk Description

Not having sufficiently robust, clear systems and processes in place to deliver high quality care and consistent achievement of relevant local, national and regulatory quality and experience standards.

Existing Control Measures	Assurance Evidence (attach on system)
Quality Impact Assessments and Equality Impact Assessments completed for all planned changes (NHSE/I).	Annual QIA assurance report
Risk registers including the corporate register are actively reviewed, risks are managed and inform Board assurance.	Risk assessments etc. and associated risks monitored via the Care Delivery Board. Trust Board informed vis Audit & Risk Committee minutes.
The Quality & Safety sections of the Corporate Report are reviewed and managed through SQAC and reported up to Trust Board	Safety & Quality Committee, Trust Board and Care Delivery Board
Patient Safety Meeting monitors incidents, including lessons learned, immediate actions for improvement and sharing learning Trust wide.	Patient safety meeting actions monitored through CQSG, learning bulletin produced.
Programme of quality assurance rounds is in place at service level which provides assurance against a range of local and national metrics.	Reports and minutes from Safety & Quality Assurance Committee and Audit and Risk Committee
Under 'Building Brilliant Basics' programme, the Trust has developed three quality priorities and associated improvement programmes to demonstrate increased quality and safety outcomes	Improvement hub to generate monthly reports to SQAC
Ward to Board processes are linked to NHSI Oversight Framework	Ward accreditation reports shared with SQAC, quality rounds outcomes report shared following each round. Programme of clinical audit supports the Trust dashboard in terms of safety and quality of care.
Acute Provider Infection Prevention and Control framework and associated dashboards and action plans for improvement.	IPC action plan and Trust Board, Safety & Quality Assurance Committee, Integrated Governance Committee, Divisional Quality Board minutes.
The Trust has a Patient Experience Group that reports against the workplan based on feedback from Children, Young People and their families, and will include representation from a wide range of stakeholders including children & young people.	Minutes of Patient Experience Group and associated workplan and dashboards monitoring a range of patient experience measures.
Trust policies and Guidelines will be regularly reviewed, up-to-date and developed in line with best practice evidence	Trust audit committee reports and minutes
CQC regulation compliance	Progress against the CQC Action Plan monitoring via Board and sub-committees
monthly review meetings with each division are held with the Medical Director and Chief Nurse to provide assurance relating to the progress of RCA investigations and completion of subsequent action plans.	Monitoring reports will be available from each review meeting
The STAT education and training program is in place in theatre to improve safety awareness and culture	monitoring of the AfPP action plan and STAT program outcomes monitored through the Surgery Divisional Board

Gaps in Controls / Assurance

1. Failure to meet administration of IV antibiotics within 1hr for C&YP with suspected sepsis
2. Patients with Mental Health needs are identified, risk assessed and appropriately managed within the organisation
3. Robust reduction programme in the number of medication incidents and near misses

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Alignment of workforce plans across the system	31/03/2021	Action captured within BAF risk 2.1
The 72hr review process will be followed for all patients who do not receive their antibiotics within the timeframe to identify themes, trends and any trust wide learning which will lead to improvement in compliance with this standard	01/07/2021	
The Trust will form a complex children programme board to improve the safety and experience of mental health patients within the Trust. Workstreams will be directed by service need and monitored through CQSG	02/08/2021	
The Quality Hub will work with the Trust Medication Safety Group to identify areas for improvement across a range of areas relating to prescribing, dispensing and administration of medication	01/09/2021	

Board Assurance Framework 2021-22

A new document management system to be launched All current policies and guidelines to be migrated The review and approval process to be updated Monitoring reports to be sent to CQSG monthly Number of out of date documents to be monitored through CQSG Board subcommittees to receive a quarterly report in relation tot he policies and guidelines which they are responsible for	31/05/2021	Task and finish group is in place and compliance has improved. Further meetings in May to ensure full compliance with all policy and guidelines
Review of the pre operative check list Development of a SOP "preparing the CYP for theatre" Review current checking requirements in line with NPSA guidance Ensure the process is in place across all areas of Trust	04/05/2021	

Executive Leads Assessment
May 2021 - Nathan Askew Risk reviewed and updated to include progress on the roll out of the DMS and compliance with policy and guideline documents which will be completed by the end of May. Recent issues relating to correct site surgery, marking and pre operative checking procedures have been captured as gaps in assurance. Work continues through the quality priorities to address the other gaps in assurance and reporting processes developed through CQSG and SQAC in relation to these programs of work.
April 2021 - Nathan Askew Risk has been reviewed. Control updated and gaps in assurance articulated. Risk has been updated following SQAC review
February 2021 - Nathan Askew This risk has been reviewed in the context of the wave three pandemic. The current mitigations in place are effective at this time. This risk is planned to be presented to March board following a full review in light of a changed health and social care landscape

Board Assurance Framework 2021-22

BAF 1.2	Strategic Objective: Delivery Of Outstanding Care	Risk Title: Inability to deliver accessible services to patients, in line with national standards, due to the adverse impact of COVID-19, a surge in urgent care and an RSV epidemic

Related CQC Themes: Safe, Caring, Responsive, Well Led, Effective		Link to Corporate risk/s: 2270, 2233		
Exec Lead: Adam Bateman	Type: Internal, Known	Current IxL: 4x5	Target IxL: 3x2	Trend: STATIC

Assurance Committee: Safety & Quality Assurance Commitee

Risk Description

Failure to meet targets and internal performance metrics due to a lack of capacity relative to demand; a loss of capacity during COVID-19 has made access to care extremely challenging. Challenges with data quality could lead to sub-optimal waiting list management and delays to care.

Existing Control Measures	Assurance Evidence (attach on system)
Controls for waiting time in the Emergency Department (ED): - Winter Plan with additional staffing and bed capacity - ED Escalation & Surge Procedure - Additional shifts to increase staffing levels to deal with higher demand - Trust-wide support to ED, including new in-reach services (physiotherapy, Gen Paeds & CAMHS)	- Daily reports to NHS England - Daily performance summary - Monthly performance report to Operational Delivery Group - Performance reports to RABD Board Sub-Committee - Bed occupancy is good
Controls for referral-to-treatment times for planned care: - Weekly oversight and management of waiting times by specialty - Weekly oversight and management of long wait patients - Use of electronic system, Pathway Manager, to track patient pathways - Additional capacity in challenged specialties - Access to follow-up is prioritised using clinical urgent signified by tolerance for delay	- Corporate report and Divisional Dashboards - Performance reports to RABD Board Sub-Committee - Use of electronic patient pathway forms to signify follow-up clinical urgency and time-frame
Controls for access to care in Community Paediatrics: - Use of external partner to increase capacity and reduce waiting times for ASD assessments - Investment in additional workforce for Speech & Language service in Sefton - Weekly oversight and management of long wait patients	- Significant decrease in waiting times for Sefton SALT - Corporate report and Divisional Dashboards - Performance reports to RABD Board Sub-Committee
Controls for access to care in Specialist Mental Health Services: - Investment in additional workforce in Specialist Mental Health Services - Extension of crisis service to 7 days - Weekly oversight and management of long wait patients	- Monthly performance report to Operational Delivery Group - Corporate report and Divisional Dashboards
Use of Challenged Area Action Boards for collective improvement in waiting times	Challenge boards live for ED, Radiology and community paediatrics
Transformation programme: - SAFER - Best in Acute Care - Best in Outpatient Care - Best in Mental Health care	- Monthly oversight of project delivery at Programme Board - Bi-monthly transformation project update to CQAC
Performance management system with strong joint working between Divisional management and Executives	- Bi-monthly Divisional Performance Review meetings with Executives - Weekly 'Executive Comm Cell' meeting held - Operational Delivery Board as a forum to collectively address challenged areas and to submit cases for investment where access to care is challenged
Urgent clinic appointment service established for patients who are clinically urgent and where a face-to-face appointment is essential	New outpatient schedule in situ
Digital outpatient channel established - 'Attend Anywhere'	Weekly tracking of training compliance and number of patients consulted via a digital appointment
Urgent operating lists	
Weekly access to care meeting to review waiting times	Minutes
Winter & COVID-19 Plan, including staffing plan	
Additional weekend working in outpatients and theatres to increase capacity	
Safe waiting list management programme to ensure no child experiences harm whilst on a waiting list for treatment	
Clinical review of long waiting patients, and harm review SOP for patients who were not tracked optimally	

Gaps in Controls / Assurance

1. addressing data quality and waiting list reporting issues through the actions contained in the 'Safe Waiting-list Management' programme: enhanced training programme; accurate waiting list and reports; validation of records affected by data quality issues; enhanced awareness through a communication and cultural piece on safe waiting list management.
2. 12 month elective restoration plan informed by modelling on capacity, demand, waiting times and workforce
3. Transformational projects in outpatients and theatres deliver increase in productivity to improve capacity, access to care and reduce waiting times

4. Provide additional capacity by sourcing capacity from the independent sector

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Alder Hey is one of five children's hospitals forming part of the "accelerator" programme, which aims to clear NHS backlogs at pace. The programme aspires to short-term delivery of 120% pre-Covid activity levels coupled with a legacy that will offer long-lasting sustainable benefits. Delivery in the 5 priority specialties to commence from July 2021.	30/09/2021	The Trust completed and submitted a data collection template detailing its accelerator schemes and costings and included activity projections/trajectories. The central accelerator team have submitted the full business case to NHS England using the trusts' completed data collection templates as a basis, which is currently awaiting final approval. The Trust prepared a position paper outlining the financial and activity impact of the elective recovery fund (ERF) and accelerator. The paper included details of the proposed accelerator schemes and their costs. Approval was given to proceed with the schemes with immediate effect.
Safe Waiting List Management programme plan to deliver good data quality, clinical reviews, clinical harm review, accurate waiting list reporting and additional RTT training.	18/06/2021	
12 month elective restoration plan informed by modelling on capacity, demand, waiting times and workforce	07/12/2020	All specialties provided with backlog recovery data as part of the 2021-22 annual planning process
Weekly specialty meetings to focus on booking IP TCI dates. Provision of additional capacity - including Accelerator Bid. Chronological booking. Theatre transformation to focus on Day Case and start times with expectation to increase number of patients per list.	30/07/2021	
RSV preparedness plan to be finalised with comprehensive arrangements and analysis that covers demand, escalation, staffing and resources	30/06/2021	

Executive Leads Assessment

0 - No Reviewer Entered

June 2021 - Adam Bateman
There has been a reduction in the number of children waiting over 52 weeks for treatment from 283 in April to 230 in May. This improvement has been driven by high levels of recovery in outpatients (113%) and elective care (107%).

The national accelerator programme will provide additional capacity through investment in equipment and staffing levels and additional sessions. We expect an additional 4,000 patients to receive treatment through this programme.

There is a threat to elective capacity in Q3 and Q4 as an RSV epidemic would see a surge in attendances and hospitalisations that would put pressure on hospital capacity and contract elective care.

May 2021 - Adam Bateman
In April there was a reduction in the backlog of patients waiting over 52 weeks for treatment, from 361 to 283. The improvement has been delivered through a focus on access to outpatient care in surgical services, and a strong recovery of services in April which delivered 105% recovery in both outpatient care and elective care.

Board Assurance Framework 2021-22

BAF 1.3	Strategic Objective: Delivery Of Outstanding Care		Risk Title: Keeping children, young people, families and staff safe during the COVID-19 pandemic		
Related CQC Themes: Responsive, Safe, Effective, Well Led, Caring			Link to Corporate risk/s: 2170		
Exec Lead: John Grinnell		Type: External,	Current IxL: 4x3	Target IxL: 3x3	Trend: STATIC

Assurance Committee: Trust Board

Risk Description
There are risks to the physical and psychology safety and wellbeing of children and young people, and staff as a result of the effects of COVID-19.

Existing Control Measures	Assurance Evidence (attach on system)
Formal strategic and tactical command arrangements in place	agendas & minutes
Detailed COVID-19/ Winter Plan agreed and being deployed	Winter 2020 Plans
Work programme on keeping our staff safe enacted	
Track record of implementing adult intensive care.	
COVID Specific Scorecard in place	Scorecard to Strategic Meetings
Work Programme established looking at keeping Children & Young People safe	Agendas / Minutes / Actions
24/7 CAMHS crisis line in-situ	Staff rota
Specialities have populated vulnerable patient template to outline risk, considerations that may affect current pathway and identify alternative	
Continued to update vulnerable shielding patients with guidance and support as per government advice	
Face masks introduced for staff and visitors	
New environment designed in the hospital and community setting to sustain social distancing and achieve high standards of IPC	
PPE suppliers and innovations strategy to ensure adequate supply	PPE predictor 4 week forward look
Operational plan to increase restoration of capacity	Tracked weekly though Communication Cell Metric Report in Operational Delivery Board
Covid-19 testing service	https://alderheynhsuk.sharepoint.com/sites/COVID19/SitePages/Staff-Testing.aspx
Covid-19 test and trace policy	Covid-19 test and trace policy
Cheshire & Mersey Gold Command in place.	Notes of meeting shared weekly
Vaccine deployment programme completed.	https://alderheynhsuk.sharepoint.com/sites/COVID19/SitePages/Covid-Vaccine.aspx
Enhanced staff welfare programme	https://alderheynhsuk.sharepoint.com/sites/COVID19/SitePages/Support%20%26%20Well-Being.aspx

Gaps in Controls / Assurance
Summer/Winter 2021 Plan to be finalised.

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Increase awareness and vigilance around keeping staff safe from Covid-19 by maintaining social distancing.	30/06/2021	New manager support pack to help oversee PPE, social distancing and hygiene compliance issued with ongoing monitoring in place.
Oversight Group initiated focussing on redeployment, temporary staffing, sickness, shielding and self-isolation, rota hub deployment, recruitment	31/05/2021	

Executive Leads Assessment
June 2021 - John Grinnell Recovery continues to progress well. Continual focus on latest IPC guidance and impact on our environment. Focus ahead of the summer on a Summer/Winter Plan which is captured in BAF action 1.2.
May 2021 - John Grinnell Progress remains positive with a focus on working environments after 21.6.21. Easing of lockdown, plans being formed to mitigate any further wave and potential RSV surge for CYP. Overall risk profile reduced.
April 2021 - John Grinnell Recovery and Restoration Programme is progressing well with more detailed roadmap focussing on recovering services, having a safe environment and keeping our staff safe. Environment group due to conclude next iteration of Covid secure reviews by early May.

Board Assurance Framework 2021-22

BAF 2.1	Strategic Objective: The Best People Doing Their Best Work	Risk Title: Workforce Sustainability and Development		
Related CQC Themes: Safe, Effective, Responsive, Well Led		Link to Corporate risk/s: 2312, 386		
Exec Lead: Melissa Swindell	Type: Internal, Known	Current IxL: 3x3	Target IxL: 3x2	Trend: STATIC

Assurance Committee: People & Wellbeing Committee

Risk Description

Failure to deliver consistent, high quality patient centred services due to
1. Not having workforce pipelines to ensure the Trust has the right people, with the right skills and knowledge, in the right place, at the right time.
2. Not supporting the conditions under which people can continuously learn, develop and grow in order to keep pace with the strategic development of the organisation.

Existing Control Measures	Assurance Evidence (attach on system)
Workforce KPIs tracked through the corporate report and divisional dashboards	Corporate Report and KPI Report to WOD
Bi-monthly Divisional Performance Meetings.	Regular reporting of delivery against compliance targets via divisional reports
High quality mandatory training delivered and reporting linked to competencies on ESR	-Monthly reporting to the Board via the Corporate Report -Reporting at ward level which supports Ward to Board
Mandatory training mapped to Core Skills Framework. Online portal enables all staff to see their compliance on their chosen IT device.	ESR self-service rolled out
Permanent nurse staffing pool to support nurse staffing numbers	Large-scale nurse recruitment event 4 times per year
HR Workforce Policies	All Trust Policies available for staff to access on intratet
Attendance management process to reduce short & long term absence	Sickness Absence Policy
Wellbeing Steering Group established	Wellbeing Steering Group Terms of Reference
Training Needs Analysis linked to CPD requirements	New Learning and & development Prospectus Launched - June 2019
Apprenticeship Strategy implemented	Bi-monthly reports to WOD and associated minutes
Engaged in pre-employment programmes with local job centres to support supply routes	Bi-monthly reports to WOD and associated minutes
Engagement with HEENW in support of new role development	Reporting to HEE
People Plan Implementation	People Strategy report monthly to Board
International Nurse Recruitment	75 skilled nurses to join the organisation across 2020/21
PDR and appraisal process in place	Monthly reporting to Board
Apprenticeship Strategy implementation	Bi-monthly reports to WOD OFSTEAD Inspection
Leadership Strategy Implementation	Bi-monthly reports to WOD
Recruitment and Apprenticeship strategy currently in development	progress to be reported to BAME task force and People and Wellbeing Committee
Employment checks and quality assurance that staff in post have the right skills, qualifications, and right to work in the post in which they are employed	Staff employment checks all on personnel files

Gaps in Controls / Assurance

1. Not meeting compliance target in relation to some mandatory training topics
2. Sickness Absence levels higher than target.
3. Lack of standard methodology to workforce planning across the organisation
4. Talent and succession planning
5. Lack of a robust Trust wide Recruitment Strategy
6. DBS renewal programme incomplete- meaning some staff in post do not hold a valid DBS certificate until the programme ahs been complete (April 2021)

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
1. Continue with regular reporting of data target hotspot areas and staff groups review methodology of accessing training	30/06/2021	Mandatory training continues to increase - focused recovery plans in place.
3. Development of a methodology to roll-out across the organisation. Plan for a workforce summit in June/July 2019	30/06/2021	to be reviewed in line with divisional workforce planning process
5. Recruitment and Apprenticeship Strategy currently being developed in line with the actions set out in the NHS people plan	31/07/2021	Recruitment actions progressing against action plan

Executive Leads Assessment

Board Assurance Framework 2021-22

June 2021 - Sharon Owen Action plans progressing. Workforce planning methodology needs to be revisited.
May 2021 - Sharon Owen Actions reviewed all are progressing against plan, gaps in controls identified to mitigate risk.
April 2021 - Sharon Owen Recovery plan of some key actions now in place.

Board Assurance Framework 2021-22

BAF 2.2	Strategic Objective: The Best People Doing Their Best Work	Risk Title: Employee Wellbeing		
Related CQC Themes: Effective, Well Led		Link to Corporate risk/s: No Risks Linked		
Exec Lead: Melissa Swindell	Type: Internal, Known	Current IxL: 3x3	Target IxL: 3x2	Trend: STATIC

Assurance Committee: People & Wellbeing Committee

Risk Description

Failure to support employee health and wellbeing and address mental health which can impact upon operational performance and achievement of strategic aims.

Existing Control Measures	Assurance Evidence (attach on system)
The People Plan Implementation	Monthly Board reports
Wellbeing Strategy implementation	Wellbeing Strategy. Wellbeing Steering Group ToRs
Action Plans for Staff Survey	Monitored through PAWC (agendas and minutes)
Values and Behaviours Framework	Stored on the Trust intranet for staff to readily access
Staff Temperature Check Reports to Board (quarterly)	Board reports and mintues
Values based PDR process	New template implemented and available on intranet. Training for managers (appraisers) delivered.
Staff surveys analysed and followed up (shows improvement)	2019 Staff Survey Report
Reward and Recognition Group schemes in place: Annual Awards, Star of the Month and quarterly Long Service Recognition Event, Annual Fab Staff Change Week.	Reward and Recognition Meetings established; reports to Wellbeing Steering Group
Leadership Strategy	Strategy implemented October 2018
Freedom to Speak Up programme	Board reports and minutes
Occupational Health Service	Monitored at H&S Committee
Time to Change implementation	Time to Change implementation
Staff advice and Liaison Service (SALS) - staff support service	
Care first - online Employees Assistance programme	
Counselling and Psychological support - Alder Centre	
Trust Briefs - keeping staff informed	
Spiritual Care Support	
Trust Wellbeing Team	Wellbeing Action Plan
Clinical Health Psychology service support for staff (including ICU)	
Resilience hub now live offering additional psychoeducational support to all staff in the region and taking self-referrals from frontline staff since 12th April	
Ongoing monitoring of wellbeing activities and resources via monthly Wellbeing Steering Group	Minutes presented to PAWC
Appointment of Wellbeing Guardian to report to Board regarding wellbeing activities and programmes of work	Report in development to assess progress against 9 WB principles outlined in national guidance document
Recovery task force established and operational	Recovery taskforce action plan
Health and Wellbeing Conversations launched	

Gaps in Controls / Assurance

1. Need to review staff counselling provision and ensure fit for purpose, coordinated with SALS and sufficient to meet demand going forward
2. Significant gap in predicting what the likely demand for staff support will be over the coming months given the unprecedented nature of this pandemic

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Referrals, triage systems and pathways to be reviewed for all staff counselling between January and March 2021 to determine future service development and delivery that meets demand and is integrated with internal and external	30/06/2021	Draft proposal sent to Fiona & Simon to be completed and presented to execs at end of June

counselling provision.		
Paper to be presented on 2.3.21 to execs outlining proposal for helping staff with their Recovery from impacts of Covid. Proposal to develop Recovery working group to develop and monitor action plan to include whole organisation debriefing programme	30/06/2021	Recovery taskforce established and meeting weekly. Recovery action plan attached
Meeting with ED leads on 18.05.21 to discuss issues and develop an acute support plan for staff. Agreed to offer SALS drop ins daily to ED w/c 24.05.21 plus 2 virtual drop ins. Department to support release of staff on shift to attend if needed. Ground TRUTH to be rolled out to department to help to build resilience and monitor anxiety and morale. SALS to explore feasibility of providing a Wingman on wheels service to the department and also access to brief massages (via an external service). Nicola Evans to email senior executive leads to ask if the department could be supported in the medium term by a Pastoral Support Volunteer service (as was set up to support redeployed staff during the cCovid-19 second wave). Team to regroup to discussing medium term support after next week.	30/07/2021	

Executive Leads Assessment
May 2021 - Jo Potier Risk reviewed. Actions updated following progress in Recovery task group and staff support pathways. No change to risk rating given ongoing uncertainty in likely impacts of Covid on workforce.
March 2021 - Jo Potier Risk reviewed. SALS resource action complete. Additional control added following appointment of Wellbeing Guardian. Actions reviewed and progress amended. No change to score.
January 2021 - Jo Potier Risk reviewed - no change to score in-month. Thorough review of risk undertaken to amalgamate risk 2181 in order to manage all actions at Executive Level.

Board Assurance Framework 2021-22

BAF 2.3	Strategic Objective: The Best People Doing Their Best Work		Risk Title: Workforce Equality, Diversity & Inclusion		
Related CQC Themes: Well Led, Effective			Link to Corporate risk/s: No Risks Linked		
Exec Lead: Melissa Swindell		Type: External, Known	Current IxL: 4x3	Target IxL: 3x2	Trend: STATIC
Assurance Committee: People & Wellbeing Committee					

Risk Description

Failure to have a diverse and inclusive workforce which represents the local population.
Failure to take steps to become an inclusive and anti-racist work place where all staff feel their contribution as an individual is recognised and valued.
Failure to provide equal opportunities for career development and growth.

Existing Control Measures	Assurance Evidence (attach on system)
WOD Committee ToR includes duties around diversity and inclusion, and requirements for regular reporting.	- Bi-monthly reporting to Board via WOD on diversity and inclusion issues - Monthly Corporate Report (including workforce KPIs) to the Board
Wellbeing Steering Group	Wellbeing Steering Group ToRs, monitored through WOD
Staff Survey results analysed by protected characteristics and actions taken by EDI Manager	monitored through WOD
HR Workforce Policies	HR Workforce Policies (held on intranet for staff to access)
Equality Analysis Policy	- Equality Impact Assessments undertaken for every policy & project - EDS Publication
Equality, Diversity & Human Rights Policy	- Equality Impact Assessments undertaken for every policy & project - Equality Objectives
BME Network established, sponsored by Director of HR & OD	BME Network minutes
Disability Network established, sponsored by Director of HR & OD	Disability Network minutes
Actions taken in response to the WRES	-Monthly recruitment reports provided by HR to divisions -Workforce Race Equality Standards - Bi-monthly report to WOD
Action plan specifically in response to increasing the diversity of the workforce, and improving the experience of BME staff who work at Alder Hey	Diversity and Inclusion Action Plan reported to Board
LGBTQIA+ Network established, sponsored by Director of HR & OD	LGBTQIA+ Network Minutes
Time to Change Plan	Time to Change Plan
Actions taken in response to WDES	- Monthly recruitment reports provided by HR to divisions - Workforce Disability Equality Standards - Bi-monthly report to WOD
Leadership Strategy; Strong Foundations Programme includes inclusive leadership development	11 cohorts of the programme fully booked until Nov 2020
BAME Risk assessments during COVID19. Evidence suggests that our BAME staff are potentially at greater risk if they contract covid 19- enhanced risk assessments have been conducted to date with 90% of BAME STAFF. Outstanding risk assessments are currently being addressed with departmental leads and managers.	90% completion of BAME risk assessments to date

Gaps in Controls / Assurance

1. Need to establish a robust action plan through the work of the BAME Inclusion Taskforce
2. Need to review the resource available to support the EDI agenda

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
2. Work with the BME and Disability Networks to develop specific action plans to improve experience.	31/12/2020	action closed as all actions being refreshed in line with new taskforce and approach to EDI
1. Work with Community Engagement expert to develop actions to work with local community	31/12/2020	action closed to be replaced by revised set of actions as a result of the taskforce and new approach to EDI
BAME Taskforce established, Claire Dove NED is leading. Taskforce is working to identify the main areas of focus for us to increase representation, improve experience, remove racism	31/03/2021	BAME taskforce have now met three times. action plan and ideas progressing/ Board update to be ready for December 2020
Specialist Trusts discussion to explore implementing an EDI team across all four Trusts.	30/06/2021	Interviews scheduled for 8th June 2021

Executive Leads Assessment

Board Assurance Framework 2021-22

June 2021 - Sharon Owen Actions progressing against plan - EDI post interviews taking place 8th June 2021
May 2021 - Sharon Owen Actions progressing against plan
April 2021 - Sharon Owen actions progressing against plan

Board Assurance Framework 2021-22

BAF 3.1	Strategic Objective: Sustainability Through External Partnerships		Risk Title: Failure to fully realise the Trust's Vision for the Park		
Related CQC Themes: Responsive, Well Led			Link to Corporate risk/s: 1241		
Exec Lead: David Powell		Type: Internal, Known	Current IxL: 3x3	Target IxL: 3x2	Trend: STATIC
Assurance Committee:	Resource And Business Development Committee				

Risk Description
The Alder Hey long term vision for the Park and Campus development which will support the health and wellbeing of both our patients, families , staff and local communities will not be deliverable within the planned timescale or budget and in partnership with the local community and other key stakeholders as a legacy for future generations

Existing Control Measures	Assurance Evidence (attach on system)
Business Cases developed for various elements of the Park & Campus	Approved business cases for various elements of the Park & Campus
Monitoring reports on progress	Monthly report to Board Stakeholder events / reported to Trust Board
Heads of Terms agreed with LCC for joint venture approved	
Campus Steering Group	Reports into Trust Board
Monthly reports to Board & RABD	Highlight reports to relevant assurance committees and through to Board
Capacity Lab have been engaged for a period of 3 months to complete a piece of work/proposal for setting up a Community Interest Company as well as supporting the Trust to bring partners on board with the development and providing some financial contributions	
Planning application for full park development.	Full planning permission gained in December 2019 for the park development in line with the vision, awaiting written confirmation.
Weekly review of status in respect of Covid 19 impact	Meeting record
The impact of Covid-19 is both on physical progress on site and from an inability to engage with community stakeholders however the team continue to pursue works liaising with the appointed contractor.	The Trust is in contact with the City Council to discharge pre-commencement conditions so that once demolition is completed the Phase 1 park reinstatement works can commence in late summer.
The Trust Development team continues to liaise closely with Liverpool City Council and the planning department to discharge pre-commencement conditions	Minutes of park development meeting
The Trust has appointed Capacity Lab for an 18 month period, they are responsible for working with the local community, planning activities in the park, supporting the local community to form an Enterprise/Community Interest Company. Whilst completing this work they will be engaging with Liverpool City council and local councillors. The work has already begun and feedback from the community is positive	Minutes of meetings SLA
Exec Design Group	Minutes of Exec Design Reviews to Campus Steering Group

Gaps in Controls / Assurance
1. Fully reconciled budget with Plan. 2. Risk quantification around the development projects. 3. Absence of final Stakeholder plan 4. COVID 19 is impacting on the project milestones

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Complete cost plan	31/01/2021	Turkington martin who provided the overall plan/vision for the park have been approached and a meting diarised to start to further develop the plan which can then go to tender, some estimation of cost will be achieved through working the plan up with Turkington Martin (Landscaping architects)
2. Agree Park management approach with LCC	01/04/2021	Discussions with LCC continue and most recently positive feedback on an agreement to lease additional car park space off site at Thomas lane sports field/car park. This is to be be agreed within the next month and lease put into place. A whole internal process on management of this is currently under discussion
Prepare Action Plan for NE plot development	30/06/2021	Workshop with PWC occurred on the 25th June, outputs to be formulated and fed back to the Trust
Complete Eaton Road Masterplan	30/06/2021	

Board Assurance Framework 2021-22

Establish Executive Design Group	31/12/2020	
Create action plan for NE plot	03/05/2021	
Review model for corporate office activity	05/04/2021	
Review and update Space Strategy	31/07/2021	
Action Plan for Community Benefits society	08/04/2021	

Executive Leads Assessment
June 2021 - David Powell Review prior to June Board
May 2021 - No Reviewer Entered Prior to May Board
April 2021 - David Powell Review prior to Campus Steering Group

Board Assurance Framework 2021-22

BAF 3.2	Strategic Objective: Sustainability Through External Partnerships	Risk Title: Failure to deliver 'Our Plan' objectives to develop a Healthier Future for Children & Young People through leadership of 'Starting Well' and Children & Young People's systems partnerships.
Related CQC Themes: Caring, Effective, Responsive, Safe, Well Led		Link to Corporate risk/s: No Risks Linked
Exec Lead: Dani Jones	Type: External, Known	Current IxL: 4x3 / Target IxL: 4x2 / Trend: STATIC

Assurance Committee: Resource And Business Development Committee

Risk Description

Risk of failure to:
- Deliver care close to home, in partnerships
- Develop our excellent services to their optimum and grow our services sustainably
- Contribute to the public Health and economic prosperity of Liverpool

Existing Control Measures	Assurance Evidence (attach on system)
Divisional Performance Management Framework - includes clear trajectories for challenged specialties to deliver	Monthly to Board via RABD and Board. (Example of monthly divisional-level detail attached)
Compliance with All Age ACHD Standard	ACHD Level 1 service now up and running; developing wider all-age network to support - agreement to host at Alder Hey
Capacity Plan identifies beds and theatres required to deliver BD plan	Daily activity tracker and forecast monitoring performance for all activity.
Sustainability through external partnerships is a key theme in the Change Programme: assurance received through Programme Board and Trust Board	Growth of specialist services through partnerships included in approved trust strategic plan to 2024 (Our Plan). Monitored at Programme Board and via Strategy and Operations Delivery Board.
Internal review of service specification as part of Specialist Commissioning review	Compliance with final national specifications
Compliance with Neonatal Standards	Single Neonatal Services Business Case approved by NHS England.
Alder Hey working in partnership with Manchester Children's to ensure collaboration/sustainability where appropriate, and support North West in national centralisation agenda	MOU with Manchester approved at Trust Board July 19. Work plan governed via NW Partnership Board (quarterly)
'Our Plan' - Final - Strategic Plan to 2024: Explicit and clear about partnership plans, our role in the system and growth that supports children and young people's needs as well as system needs	'Our Plan' approved at Trust Board October 2019
'One Liverpool' plan to 2024: system plan detailing clear strategic intent re: Starting Well and children and young people's services	Evidences alignment of Alder Hey's plan with those of our integrated care system and evidences the drivers for key partnerships within.
Involvement of Trust Executives, NEDs and Governors in partnership governance arrangements	ToR & minutes - NW Paediatric Partnership Board
Gap / risk analysis against all draft national service specification undertaken and action plans developed	Annual assessment against all service specifications led through quality team; SDIPs put in place in agreement with commissioners as a result to reach compliance
Involvement of Trust Executives in partnership governance arrangements	ToR & minutes - NW Paediatric Partnership Board. Hosted ODN Assurance reporting to RABD (2 x per year)
Implementation of the 'Starting Well' partnership group for One Liverpool(developing - replaces Children's Transformation Board). SRO Louise Shepherd confirmed.	
C&M C&YP Recovery Plan - Alder Hey Leadership ensures alignment with Our Plan	C&M C&YP Recovery Plan Narrative
One Liverpool - Provider Alliance action plan	Agreed plan per Provider Alliance 25.9.20 - inclusive of Children, Young People and Families priorities.
C&M Children's Transformation Programme - AH hosting agreed and new programme for 2021+ under establishment	Presentation to C&M W&C Programme to agree C&M priorities - led by Alder Hey (Dec 20). Approved paper to C&M HCP re establishment of the new C&M CYP Programme (Nov 20). Programme submission to C&M HCP for set up of new CYP Programme (Mar 21) supported by HCP (ICS)

Gaps in Controls / Assurance

1. Inability to recruit to highly specialist roles due to skill shortages nationally.
2. Trust has sought derogation in a number of service areas where it does not meet certain standards and is progressing actions to ensure compliance by due date.

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
6.Develop Operational and Business Model to support International and Private Patients	30/09/2021	Plan for Private Patients & International reviewed at Exec strategy away day 23.4.21. Continued commitment to developing the business model, define the plan & include in the proposal to Clinicians as part of future planning assurance of Trust commitment to achieve this long-term goal.

Board Assurance Framework 2021-22

1. Strengthening the paediatric workforce	30/09/2021	Strengthened work across paediatric network continues; current focus on developing C&M RSV surge plan with embedded mutual aid arrangements, connected into NW RSV surge plan (submitted June 2021)
Full programme proposal implementation; Funding flows into AH from C&M/NHSE Recruit to all key programme roles - beginning with Programme Director Establish C&M CYP Transformation Board	30/09/2021	CYP Programme Director recruited to - starts 1st July. Further PMO roles agreed and to proceed recruitment. Notification received of 21/22 programme allocations from NHSE.

Executive Leads Assessment
June 2021 - Dani Jones Risk reviewed; no change to score in month. Progressing implementation of C&M CYP programme. System-wide RSV surge plan under finalisation.
May 2021 - Dani Jones Risk reviewed; no change to score in month, though rapid system developments following White Paper and Covid; CYP increasingly prioritised & aligned work ongoing to sustain this, which will support mitigation of this risk in medium term. Progress with C&M CYP and Strategic planning at Exec & Board during April.
April 2021 - Dani Jones Risk reviewed; no change to score in month. Progress in C&M CYP - evidence attached.

Board Assurance Framework 2021-22

BAF 3.4	Strategic Objective: Sustainability Through External Partnerships	Risk Title: Financial Environment		
Related CQC Themes: Safe, Effective, Responsive, Well Led		Link to Corporate risk/s: No Risks Linked		
Exec Lead: John Grinnell	Type: Internal, Known	Current IxL: 4x4	Target IxL: 4x3	Trend: STATIC

Assurance Committee: Resource And Business Development Committee

Risk Description

Failure to meet NHSI target and affordability of Trust ongoing Capital requirements.

Existing Control Measures	Assurance Evidence (attach on system)
Organisation-wide financial plan.	Monitored through Corporate Report
NHSi financial regime and Use of Resources risk rating.	Specific Reports (i.e. NHSI Plan Review by RABD)
Financial systems, budgetary control and financial reporting processes.	- Daily activity tracker to support divisional performance management of activity delivery - Full electronic access to budgets & specialty performance results - Financial in-month and forecast position reported through SDG, Exec Team, RABD Ops Board and Trust Board - Financial recovery plans reported through SDG and RABD - Internal and External Audit reporting through Audit Committee.
Capital Planning Review Group	5 Year capital plan ratified by Trust Board
Monthly performance review meetings with Divisional Clinical/Management Team and the Executive	Monthly Performance Management Reporting with '3 at the Top'
Weekly meeting with divisions to review forward look bookings for elective and day case procedures to ensure activity booked meets contract and recovery plans. Also review of status of outpatient slot utilisation	Monitored through Exec Comm Cell and Exec Team
Weekly Sustainability Delivery Group overseeing efficiency programme	Weekly Financial Sustainability delivery meeting papers
CIP subject to programme assessment and sub-committee performance management	Tracked through Execs / RABD
RABD deep dive into key financial risk areas at every meeting	RABD Agendas, Reports & Minutes
Weekly COVID financial update to Strategic Command	Agenda and Presentations

Gaps in Controls / Assurance

1. Uncertainty of H2 21/22 framework and beyond
2. Affordability of Capital Plans
3. Cost of recovery, winter & RSV escalating
4. Long Term Plan shows £3-5m shortfall against breakeven
5. Long Term tariff arrangements for complex children
6. Potential system restraint on capital plans

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
4. Long Term Financial Plan	31/07/2021	Work ongoing on financial strategy for H2 and beyond for both capital and I&E. Updates are being provided through RABD and Trust Board.
2. Five Year capital plan	31/07/2021	Update provided at May RABD on 5 year capital programme with further work underway and to be represented to RABD in July.
1. Uncertainty of H2 21/22 framework and beyond	30/09/2021	H1 Plan submitted as breakeven in line with C&M target. This includes assumptions regarding delivery of activity levels above the national targets and access to the Elective Recovery scheme incentive. SDG is managing delivery of the plan. Executive panel agreed to review new investment and cost controls.

Executive Leads Assessment

June 2021 - Rachel Lea
Risk reviewed and actions updated to reflect latest position.

May 2021 - Rachel Lea
Risk reviewed and updated to reflect 21/22 risks and actions, controls being taken

April 2021 - Rachel Lea
Risk reviewed and updated to reflect latest position

Board Assurance Framework 2021-22

BAF 4.1	Strategic Objective: Game-Changing Research And Innovation		Risk Title: Failure to deliver against the trust strategy and deliver game changing Research and Innovation that has positive impact for Children and Young People.		
Related CQC Themes: Well Led			Link to Corporate risk/s: No Risks Linked		
Exec Lead: Claire Liddy		Type: Internal, Known	Current IxL: 3x3	Target IxL: 3x2	Trend: STATIC

Assurance Committee: Innovation Committee

Risk Description
The trust strategy requires the growth of game changing research and innovation activities to enable an increase in R&D investment levels and generate commercial opportunity. The failure to deliver R&I strategies could result in an inability to achieve growth and new partnerships plans which will limit R&D investments and delay new discoveries. The delivery of the R&I activities may also expose the Trust to contractual and reputation risks due to the need to enter into legal agreements with academia, large corporate's, SMEs and investors. The delivery of the R&I activities will lead to industry data collaborations and AI with commercial contracts which will require robust data governance and ethics.

Existing Control Measures	Assurance Evidence (attach on system)
R&I: RABD review of commercial issues per Corporate governance manuals, oversight of Innovation Ltd Corporate governance manual and oversight of deal diligence (commercial and reputational) . Trust Board oversight of shareholding and equity investments and intellectual property.	Reports to RABD / Trust Board and associated minutes
R: Establishment of Research Management Board	Research Management Board papers.
I: Innovation Committee and RABD Committee	Committee oversight of Innovation strategy with NED expertise
I: Clear Management Structure and accountability within Innovation Division	ESR Divisional Hierarchies
R&I: Plans for joint research & innovation clinical leadership	Job Description and Hierarchy
R: Clinical trials Covid recovery plan operational.	Trust Board papers
R: research division monthly focus on research at Care Delivery Board to support strategy deliver.	Care Delivery Board papers
I: Legal Partner now in contract to advise on partnership structure and intellectual property	Letter of engagement
R&I: Trust Policies and online declaration portal (gifts & hospitality, sponsorship etc.)	Trust Policies and digital audit trail to audit committee
R&I: Formal Press Releases and external communications facilitated through communications department	Communications Strategy and Brand Guide
R&I: Industry Partner and AI Data governance. To adopt Trust DPIA's/DSA's and IG Steering Commitee standard process and approvals	Policy and SOPs

Gaps in Controls / Assurance
1. Availability and incentivisation model for resources to deliver strategy. 2. Capacity for business development and inward investment. 3. External factors such a Covid and Brexit creating delays in expansion plans. 4. Capacity of clinical staff to participate in research/innovation activity. 5. Capacity of clinical services to support research/innovation activity. 6. Availability of space for expansion of commercial research/innovation growth.

Executive Leads Assessment
June 2021 - Claire Liddy JUNE 21 - Risk review and updated for data risks.
May 2021 - Claire Liddy MAY 21 - risk review and update to include data / AI. no change to score
April 2021 - Claire Liddy Risk reviewed 9/4/21 - no change.

Board Assurance Framework 2021-22

BAF 4.2	Strategic Objective: Delivery Of Outstanding Care		Risk Title: Digital Strategic Development & Delivery		
Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led			Link to Corporate risk/s: 2265, 2143, 2235, 2310		
Exec Lead: Kate Warriner		Type: Internal, Known	Current IxL: 4x1	Target IxL: 4x1	Trend: STATIC

Assurance Committee: Resource And Business Development Committee

Risk Description

Failure to deliver a Digital Strategy which will place Alder Hey at the forefront of technological advancement in paediatric healthcare, failure to provide high quality, resilient digital and Information Technology services to staff.

Existing Control Measures	Assurance Evidence (attach on system)
Improvement scheduled training provision including refresher training and workshops to address data quality issues	Working towards Informatics Skills and Development Accreditation (Aug 2019). Training improvements identified through refreshed Digital Strategy Update Sept: ISD Excellence in Informatics Level 1 accreditation achieved
Formal change control processes in place	Exec agreed change process for IT and Clinical System Changes
Executive level CIO in place	Commenced in post April 2019
Quarterly update to Trust Board on digital developments, Monthly update to RABD	Board agendas, reports and minutes
Digital Oversight Collaborative in place & fully resourced - Chaired by Medical Director	Digital Oversight Collaborative tracking delivery
Clinical and Divisional Engagement in Digital Strategy	Implementation of fortnightly huddle with divisions from April 2019. Divisional CCIOs recruited. Divisional IT Leads in place.
NHSE & NHS Digital external oversight of programme	NHSD tracking of Programme through attendance at Programme Board and bi-monthly assurance reports.
Digital Strategy approved by Board July 2019, mobilisation in place to new governance and implementation arrangements	Digital Futures Strategy
Disaster Recovery approach agreed and progressed	Disaster recovery plans in place
Monthly digital performance SMT meeting in place	ToRs, performance reports (standard agenda items) KPIs developed
Capital investment plan for IT including operational IT, cyber, IT resilience	Capital Plan

Gaps in Controls / Assurance

Cyber security investment for additional controls approved - dashboards and specialist resource in place
Transformation delivery at pace - integration with divisional teams and leadership from divisional CCIOs
Approach to training under review

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Refreshed Digital Training Strategy - ensuring staff have the appropriate skills and training in digital systems	01/06/2021	Training strategy developed and in place
Implementation of Alder Care Programme	01/10/2021	Programme progressing, a number of work streams with challenges being progressed.

Executive Leads Assessment

June 2021 - Kate Warriner
BAF reviewed, good progress against actions.

May 2021 - Kate Warriner
BAF reviewed, progress being made. 21/22 plans in place. Refresh of strategy scheduled towards the end of 21/22 to be in place for 22/23 onwards.

April 2021 - Kate Warriner
BAF reviewed, good progress in place

Audit and Risk Committee

Confirmed Minutes of the meeting held on **Thursday 22nd April 2021**
Via Microsoft Teams

Present:	Mrs. K. Byrne (Chair)	Non-Executive Director	(KB)
	Mrs. F. Marston	Non-Executive Director	(FM)
	Mrs. A. Marsland	Non-Executive Director	(AM)
In Attendance:	Mr. G. Baines	Assistant Director, MIAA	(GB)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Dr. U. Das	Director of Medicine	(UD)
	Mr. J. Grinnell	Director of Finance	(JG)
	Mr. K. Jones	Associate Finance Director	(KJ)
	Mrs. R. Lea	Associate Director of Finance	(RL)
	Mrs. V. Martin	Counter Fraud Specialist, MIAA	(VM)
	Mrs. K. McKeown	Committee Administrator	(KMC)
	Mr. H. Rohimun	Executive Director, Ernst and Young	(HR)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Ms. K. Stott	Senior Audit Manager, MIAA	(KS)
	Ms. C. Umbers	Assoc. Director of Nursing and Governance	(CU)
Apologies:	Mr. A. Bass	Director of Surgery	(AB)
	Ms. L. Cooper	Director of Community Services	(LC)
	Mr. R. Tyler	E&Y Accounts Manager	(RT)
Item 21/22/05	Ms. C. Davidson	KPMG	(CD)
Item 21/22/20	Mrs. L. Shepherd	Chief Executive	(LS)

21/22/01 Introductions and Apologies

The Chair welcomed everyone to the meeting and noted the apologies that were received.

21/22/02 Minutes from the Meeting held on the 21st January 2021
Resolved:
The minutes from the meeting that took place on the 21.1.21 were agreed as an accurate record of the meeting.

21/22/03 Matters Arising and Action Log

Action 19/20/50.6: *Progress Report MIAA* (*To suggest a mechanism to review the effectiveness of External Audit for the 2019/20 accounts*) – It was agreed to try and acquire information nationally in terms of mechanisms/products that organisations are using to review the effectiveness of external audit. It was agreed to provide an update during September's meeting. **ACTION TO REMAIN OPEN**

Action 20/21/38.2: *Anti-Fraud Progress Report, Q2 (Consider the nomination of a Fraud Champion at Alder Hey to help raise awareness of this area of work. Advise Virginia*

Martin of the nominee's name) – It was agreed that a brief update would be provided once Ken Jones has completed the Fraud Champion training and given some thought in respect to progressing the work of the Fraud Champion Trust wide. It was agreed to close this action as the Trust now has a Fraud Champion. **ACTION CLOSED**

Action 20/21/29.2: *Presentation on Risk Management Process (Division of Medicine to present in January)* – This action has been included on the workplan. **ACTION CLOSED**

Action 20/21/45.1: *Update on the Recommendations within the Acorn Report (Agree a date via the Innovation Committee in which to provide assurance to the Audit Committee on any new arrangements that have been made in respect to the three live companies)* – It was agreed to provide Committee members with an update on the three remaining Acorn contracts, via e-mail. In terms of governance and the framework for innovation operations, it was agreed to submit a report in September to provide an overview of the work that has taken place and how it has been implemented. This item has been included in the Committee's workplan. **ACTION TO REMAIN OPEN**

It was also agreed to discuss a way forward in respect to the Innovation Committee providing assurance to the Audit and Risk Committee on these areas of work.

21/22/03.1 **Action: KB/ES/RL**

Action 20/21/49.1: *Fraud Risk Matrix (Update to be provided to the Committee following Deloitte's review of VFM in purchasing PPE)* – It was confirmed that Deloitte haven't progressed this work to date, therefore it was agreed to conduct an internal review of a small number of cases using a conflicts of interest lens. **ACTION TO REMAIN OPEN**

Action 20/21/51.1: *Brilliant Basics Programme (Provide an update on the outcome of the Brilliant Basics pilot that took place in December 2020)* – An update was provided during April's meeting. **ACTION CLOSED**

Action 20/21/51.2: *Brilliant Basics Programme (KPMG to liaise with Cathy Umbers to ensure that the Brilliant Basics Programme links in with the Trust's risk management process)* – This meeting hasn't been arranged to date. **ACTION TO REMAIN OPEN**

Action 20/21/55.1: *Board Assurance Framework (Discuss the risk relating to 'Keeping children, young people, families and staff safe' in order to ensure that there is no overlap between this and the 'access' risk owned by Adam Bateman)* – This risk has been reviewed and updated. **ACTION CLOSED**

Action 20/21/57.1: *Non-Clinical Claims/Clinical Claims (Initial discussion to take place between ES/JG re the examining of clinical and non-clinical claims jointly from a value for money lens to see what the Trust is obtaining from NHS Resolution versus the Trust's solicitors. Following discussion, arrange for a meeting to take place with the Chair to discuss the progression of this piece of work)* – This item is to be included on July's agenda. **ACTION TO REMAIN OPEN**

Action 20/21/59.1: *Update on Outstanding Actions from the Consultant Job Planning Audit (Provide an update once the new job planning portal is in operation)* – Provide an update once the new job planning portal is in operation. **ACTION TO REMAIN OPEN**

Action 20/21/61.1: *Progress against actions from the Audit and Risk Committee Self-Assessment (Discuss and agree an appropriate process for the self-assessment of the Trust's Assurance Committees, taking into account the governance reset, and submit a recommendation to the Audit and Risk Committee)* – It was confirmed that each Assurance Committee will be submitting an annual report for 2020/21. **ACTION CLOSED**

Action 20/21/61.2: *Progress against actions from the Audit and Risk Committee Self-Assessment (Discuss the possibility of the Associate Director of Nursing and Governance role moving to one of oversight of risk to enable a 'Risk Management Opinion' to be submitted to the Audit and Risk Committee on an annual basis and over what time frame this can be achieved)* – It was confirmed that this action will be addressed as part of the review of the Audit and Risk Committee and Care Delivery Board. **ACTION CLOSED**

Action 20/21/63.1: *Development of a Robust Process for Gifts and Hospitality (Submit a report on gifts and hospitality declarations using the data from the new electronic system)* – This item will be submitted to the Committee in July. **ACTION TO REMAIN OPEN.**

Action 20/21/72.1: *Board Assurance Committee (Cheshire and Merseyside Integrated Care Systems (ICS) – Liaise with Dani Jones to discuss as to whether a risk relating to The Cheshire and Merseyside ICS should be included in the Board Assurance Framework (BAF)/Corporate Risk Register)* – It was confirmed that this action is being addressed at BAF and corporate risk level. **ACTION CLOSED**

Action 20/21/73.1: *Trust Risk Management Report (Provide an update on the high/moderate risks and include a graph in the report to show movement of risks)* – An update on the high/moderate risks was incorporated in the report and a graph has been included to show the movement of risks. **ACTION CLOSED**

Action 20/21/73.2: *Trust Risk Management Report (Provide a regular update on the risks with an overdue date and risks with no agreed action plan)* - It was agreed to express data as a percentage as well as numerically in future reports. **ACTION CLOSED**

Action 20/21/76.1: *Internal Audit Progress Report (Data Quality Report - Submit a report on the next steps for the Trust's Informatics and Data Quality Service and provide a draft outline of the Data Quality Strategy. Provide a regular update to the Audit and Risk Committee on Data Quality)* – This item will be submitted to the Committee in July. **ACTION CLOSED**

Action 20/21/79.1: *Update on Progress Ernst and Young (Submit the final version of the draft External Audit Plan for 2020/21 to the Committee on the 22.4.21 for approval)* - The Committee received the final version of the External Audit Plan for 2020/21 during April's meeting. **ACTION CLOSED**

Action 20/21/84.1: *Meeting Review* (*Liaise with John Grinnell to discuss a proposal for inviting the Divisions to future Committee meetings to provide an update on risk)* **–** This action will be addressed as part of the review of the Audit and Risk Committee and Care Delivery Board, in Q1. **ACTION CLOSED**

21/22/05 Brilliant Basics Programme update

The Chair welcomed Chaellene Davidson from KPMG who had been invited to the

meeting to provide an update on the Brilliant Basics Programme. A number of slides were presented to the Committee and the following points were highlighted:

- The aim for Alder Hey is to embed risk management in standard work and create a mechanism for driving improvements within the teams:
  - Strategic Plan - Quality Assurance/Planning.
  - Daily Continuous Improvement via the use of Quality Control.
  - Step-change improvement via Quality Improvement.
- Building Brilliant Basics and Clinical Quality Improvement Programme:
  - Quality Rounds.
  - Dashboard.
  - Ward Accreditation.
- Building Brilliant Basics in Practice (Ward 4C Example):
  - Prioritisation and shared objectives.
  - Understanding the current state and root cause.
  - Trialling new improvement ideas.
  - Next steps.
- Tools and routines to increase the focus on risk for ward teams:
  - Unit leadership teams.
  - Scorecards.
  - A3 problem solving.
  - Planning discussions.
  - Daily improvement huddles.
  - Process standard work.
  - Leader standard work.
  - Process observation.

Anita Marsland felt that the Brilliant Basics Programme will provide a closing of the loop for staff, as described during the presentation. It was reported that the organisation will be looking for evidence to ensure that this outcome is achieved, and that the programme is working.

Fiona Marston pointed out that in order for the programme to progress it will require full co-operation from staff and queried as to how the organisation knows that this is what teams want. It was reported that improvement ideas are being submitted by staff members and the Brilliant Basics Programme has an approach that focuses on risk and safety thus raising awareness. There is also going to be a huge communications and engagement piece dedicated to the Brilliant Basics Programme to ensure that staff members are in agreement to support the Trust and the programme.

John Grinnell advised the Committee that the programme has been adapted to make sure that the Trust listens to staff in terms of what it is that they want, and drew attention to the importance of having a more formal way of testing this independently and being able to evidence the outcome.

The Chair felt that the presentation brought the programme to life and offered assurance. On behalf of the Committee, the Chair thanked Chaellene Davidson for providing an update on the programme.

21/22/06 **Risk Management Strategy; including Risk Management Policy and Procedure**

The Committee received the Risk Management Strategy and the Risk Management Policy and Procedure. An overview of the documents was provided, and members were of the consensus that the document was far more user friendly with the policy complimenting the strategy in terms of procedure around risk assessments and risk analysis. The Chair advised that there may be some slight amendments to the documents following the introduction of the organisation's risk appetite.

Resolved:
The Audit and Risk Committee approved the Risk Management Strategy and the Risk Management Policy and Procedure.

21/22/07 **Board Assurance Framework Report (BAF)**

The Audit and Risk Committee received an overview of the BAF as at the 31st of March 2021. The following points were raised:

- It was reported that BAF risk 1.1 has been updated following a thorough review by the Chief Nurse, Nathan Askew, and a number of additional controls have been agreed.
- The Committee was advised that the Director of Strategy, Dani Jones, is conducting a very granular and thorough piece of work on the Trust's governance framework for partnerships which is starting to emerge as a strong theme for the future, especially with ICSs in development. Further attention will be given to the partnership risk over the coming months.
- It was confirmed that MIAA has given the Trust a good opinion in terms of the organisation's assurance framework for 2020/21, and it was pointed out that the Trust is looking to review its strategic risks in order to reframe them for 2021/22.
- It was reported that the Assurance Committees have scrutinised the BAF risks on a regular basis throughout the year. As a result of this it was felt that the Trust is in a strong position.

Resolved:
The Audit and Risk Committee received and noted the BAF update as at the 31.3.21.

21/22/08 **Care Delivery Board; including Corporate Risk Register**

The Committee received a highlight report from the Chair of the Care Delivery Board, John Grinnell, following the meeting on the 18.3.21.

John Grinnell provided an overview of the meeting and advised of the three key issues to be escalated to the Audit and Risk Committee; access to services, records management and medicines management. Attention was also drawn to emerging risks relating to partnerships. The Chair of the Care Delivery Board felt that the Board is continuing to gain momentum in terms of its oversight of risk and pointed out that a review of significant risks was led by the risk owners during the meeting. It was confirmed that further work is required around strategic workforce risks going forward.

Corporate Risk Register

The Committee received an update on the Corporate Risk Register (CRR) activity from the 1.1.21 to the 10.4.21. The following points were raised:

- It was reported that section 2 of the report (*summary of the CRR*) identifies a consistent improvement in respect to closed/reduced risks. It was confirmed that there are a total of 11 open high risks in this reporting period.
- There are 7 high risks with static risk scores that are being managed well. All risks have action plans that are showing progress, and there are none past the expected date of completion.
- 2 new risks have been incorporated in table 2 which relate to the new Neonatal Unit that is being built on the site of Alder Hey; medical oxygen and medical air. Work is taking place to mitigate these risks therefore the Trust is expecting to see improvements over the next couple of months.
- The Committee was advised that there is only one longstanding risk on the register which relates to insufficient funding to complete the park. It was confirmed that this risk is being managed and is part of a long-term project.
- The Chair queried as to whether the risk score of the risk relating to the pipe issue across the hospital has been reduced. It was reported that this risk now has a score of 12 as the prevalence of issues have reduced but there is an active monitoring, testing and replacement programme being undertaken. The Trust is challenging the longer-term strategy and it has been agreed to establish a working group within the next month to look at building risks. The acute risk is lower at the present time, but it is important to keep a focus on the longer-term strategy. It was agreed to provide the Trust Board with an update once the group has met

21/22/08.1 **Action: JG**

- Fiona Marson queried as to how the Trust knows it has identified all of its risks especially when a new project commences. It was reported that the organisation has a risk identification/assessment process in place and in addition to this each project has its own risk register.

Resolved:
The Audit and Risk Committee noted the update from the Care Delivery Board and received the Corporate Risk Register. It was agreed that the Committee will be provided with the approved minutes from the Care Delivery Board in addition to the update.

21/22/09 **Trust Risk Management Report**

The Committee received the Trust's Risk Management report in order to scrutinise the effectiveness of risk management throughout the Trust. The assurance presented in this report is a direct reflection of the evidence available on the electronic Ulysses risk management system at the time of reporting. The following points were raised:

- There are currently 315 risks on the Trust Risk Register compared to 359 in the previous reporting period, inclusive of 12 BAF risks. There has been a consistent focus to manage high/extreme risks to a manageable level, with evidence of effective actions to mitigate to target level.
- The Trust continues to have a high number of moderate risks with a number of high/moderates. These risks have decreased during this reporting period as a

result of the work that is being conducted by the Divisions and Corporate services.

- It was reported that between the 1.2.21 and the 31.3.21 46 risks were closed in this reporting period, and a further 27 risks were identified, assessed and uploaded to the Trust's register. 7 risks were assessed as requiring an increase in risk rating with 27 reviews resulting in a decreased risk rating, however there are two areas of concern identified from the data on the register; 72 of the identified risks have not been reviewed within the agreed timeframe and 27 of the identified risks do not have actions to support mitigation of these risks. None of these risks were high or moderate but further work is required to address them.
- A discussion took place around the profile of risks and the risks with no risk rating identified. John Grinnell agreed to liaise with the Health and Safety department, who have a number of risks that haven't been risk ranked.

21/22/09.1 **Action: JG**

Anita Marsland referred to the risks without mitigating actions and queried the next steps to address this area of work. It was reported that monthly validation meetings take place with the Divisions and Corporate Functions to review their risk registers and address these issues. The Chair pointed out that the reason for introducing this report was to enable the Committee to raise any concerns and request a deep dive into a specific risk/s via the Care Delivery Board but felt that there had been an overall improvement across the Trust in respect to the management of risk.

Resolved:
The Audit and Risk Committee received and noted the Trust's Risk Management Report.

21/22/10 CQC Action Plan

The Committee received version 9 of the CQC Action Plan for 2020. The following points were highlighted:

- Recommendation 8 *(The Trust should review their internal risk identification methods to ensure that they identify and mitigate risks in a timely manner – Regulation 17)* - It was reported that this action has progressed, as highlighted in the reports submitted during the meeting. The Committee was advised that there is also a lot of work taking place around the system which includes the training element of the recommendation. It was confirmed that this action is on track.

Resolved:
The Audit and Risk Committee noted the CQC Action Plan.

21/22/11 Annual Report on Risk Management, 2020/21
Resolved:
The Audit and Risk Committee received and noted the contents of the Risk Management Annual Report.

21/22/12 Internal Audit Progress Report

The Internal Audit Progress Report was submitted to the Committee to provide an update on assurances, key issues and progress against the Internal Audit Plan for 2020/21 and to support the Head of Internal Audit Opinion. The following points were highlighted:

- MIAA Issued 4 final reports; Mandatory Training, Safety Standards for Invasive Procedures and Delivery Management Office all of which received substantial assurance. It was reported that the work for the Assurance Framework Opinion (stage 3) has been completed.
- *Data Security and Protection Toolkit* – Fieldwork has been completed and a draft report has been issued.
- *Audit Plan* – It was confirmed that there have been no requests for changes to the Audit Plan therefore it has been completed. MIAA offered thanks to the Trust's leads, especially Ken Jones, for the help that was provided to MIAA during 2020/21 to progress the audits for the current year's plan.

The Chair drew attention to the general performance indicators in the report and felt that the timeliness element should be rated as green rather than amber.

Resolved:
The Audit and Risk Committee received and noted the contents of the Internal Audit Progress Report.

21/22/13 Internal Audit Follow Up Reports

The Committee received an update on the status of the implementation of agreed recommendations. The following points were highlighted:

- There were a total of twenty seven recommendations originally made which have been followed up. There are still six actions outstanding, of which, four appertain to consultant job planning. A revised deadline of the 30.6.21 has been agreed for completion of these actions.

  Urmi Das advised of the challenges that have been experienced in respect to progressing the new system that has been implemented for consultant job planning and drew attention to the actions that have taken place to ensure progress by June.

  The Chair felt that this area of work has progressed during the last six months but pointed out that this is an annual process and needs to be completed shortly otherwise it will remain on the action log for another year. Urmi Das confirmed that 50% of this work will be completed by June 2021.

Resolved:
The Audit and Risk Committee received and noted the contents of the Internal Audit Follow Up Report.

21/22/14 **Draft Director of Audit Opinion and Annual Report, 2020/21**

The Audit and Risk Committee received the 2020/21 Head of Internal Audit Opinion for the Trust, together with the internal audit coverage and output during 2020/21. The following points were highlighted:

- It was reported that the overall opinion for the period from the 1st of April 2020 to the 31st of March 2021 is 'Substantial Assurance' as there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.
- There were 39 recommendations raised as part of the reviews undertaken during 2020/21. All recommendations raised by MIAA were accepted by management, of these recommendations; 0 were critical and 1 was a high-risk recommendation in relation to the review of Non-Clinical Claims.
- Attention was drawn to a number of areas for consideration when compiling the Trust's Annual Governance Statement, as highlighted on page 14 of the report.
- It was reported that the Data Protection Security Toolkit submission date has been deferred to the end of June 2021. It was confirmed that this won't affect the overall audit opinion.
- The Committee was advised that MIAA complies fully with the professional best practice, internal audit standards and legal requirements. MIAA assess their compliance with Public Sector Internal Audit Standards (PSIAS) each year.
- The Chair drew attention to the additional items that are to be included in the final report which will be submitted in May; statistics on specific KPIs that have been agreed and analysis around the Client Satisfaction Questionnaire that is issued after each audit, to see whether there have been any changes to processes as a result of client feedback.
- The Chair felt that in light of the obstacles that were experienced as a result of the pandemic, to receive a substantial opinion from MIAA is a fantastic outcome. The Chair also drew attention to the risk management process and that it is accelerating in its evolution.

Resolved:
The Audit and Risk Committee received and noted the draft Director of Audit Opinion and Annual Report, 2020/21

21/22/15 **Final Internal Audit Plan for 2021/22**

The Committee was advised of the scope and planned days of the Operational Internal Audit Plan for 2021/22. Attention was drawn to the "reserve list" on page ten of the report that was compiled for consideration and discussion by the Committee.

The Chair felt that it is useful to review the reserve list from a Committee perspective to see if there are any audits that are more important than those on the draft Plan. It was reported that the Safety and Quality Assurance Committee (SQAC) has agreed a six-month period to enable work to be conducted around the changing consent process for children under 16 with capacity, therefore the audit for this area of work has been deferred until 2022. It was pointed out that as a result of this there is potentially an empty audit slot and it was queried as to whether this should be left open and reviewed at a later date or whether the Committee should promote an alternative audit. Following discussion, it was

agreed to leave this slot open and discuss this matter further during September's meeting to see if there is anything on the horizon that needs addressing.

21/22/15.1 Action: KB

The Chair initiated a discussion around the audit of key financial controls and queried as to whether a different approach should be implemented for this area of work as 10% of the Plan is taken up with these audits which reduces the number of days that the Trust is able to proactively influence. The Chair pointed out that these audits are important but felt that the Trust has a good track record and strong audit outcomes in these areas and therefore queried as to whether it makes sense to spend 25 days on these audits.

The Chair provided an overview of what an alternative approach could look like, for example, conduct an audit of one of the financial systems on an annual rolling basis and review a number of fundamental controls; bank reconciliation/control account reconciliations as this would release time in which to conduct another potential audit. The Chair asked for comments from Committee members regarding this matter.

Anita Marsland queried as to whether changing the approach will affect how the Trust is perceived and queried as to how much weight does that level of assurance have in terms of the Trust being supported financially through the national system. John Grinnell informed the Committee that the perception point would come into force if a process wasn't working or something went wrong then questions would be raised around the Trust's decision-making process in respect to the changed approach.

Hassan Rohimun pointed out that failures in control could impact the Trust financially as well as operationally, and advised that the Committee would need to think about the annual declarations that the Accounting Officer makes and also the responsibilities of the Audit and Risk Committee in ensuring effective internal controls, including financial controls. Therefore, it will be imperative to think about the types of assurance that will be required to make these declarations if the Trust moves away from the type of Internal Audit coverage that it currently receives. It was also felt that it is important to recognise that the Trust is operating really well partly because it is subject to regular Internal Audit coverage.

Gary Baines informed the Committee that there are certain core controls across all systems that you wouldn't remove but felt that there was merit in conducting a deep dive into a couple of systems whilst reviewing core controls on an annual basis. Attention was drawn to the possible risk of the systems non-compliance with controls, but it was felt that it was worth having a debate regarding an alternative approach. A suggestion was made in respect to conducting a piece of work to look at reducing the financial key controls audit to 15 days to highlight what the Plan would look like and have an informed view.

Following the conclusion of discussion, the Chair confirmed that the Audit and Risk Committee approved the Internal Audit Plan for 2021/22 subject to a place marker being held for the Consent Audit which will be revisited in September 2021. It was also agreed to conduct a piece of work over the next twelve months, in association with MIAA, to look at what the Internal Audit plan would look like if a different approach was taken by the Trust on key financial controls.

21/22/15.2 Action: KB/ES/JG/MIAA

Resolved:
The Audit and Risk Committee approved the Internal Audit Plan for 2021/22 subject to a place marker being held for the Consent Audit.

21/22/16 **Internal Audit Charter**
Resolved:
The Audit and Risk Committee received and approved the Internal Audit Charter.

21/22/17 **Anti-Fraud Annual Report 2020/21**

The Audit and Risk Committee received the Anti-Fraud Annual Report for 2020/21. The Annual Report annual report is based on the progress reports submitted during the year and the four key areas of the NHS Counter-Fraud Authority Standards. This report has been submitted to the Director of Finance and the Associate Director of Finance for consideration by the Audit and Risk Committee. The following points were highlighted:

- The Trust's annual Self-Review Toolkit was submitted in accordance with the NHS Counter-Fraud Authority (CFA) provider requirements and two other CFA mandatory exercises were completed.
- A fraud risk exercise was completed and there is a covering risk on Ulysses with the Fraud Risk Matrix attached as a supporting document.
- The Trust's Associate Director of Finance, Ken Jones, has been nominated to the NHS CFA as the Trust's first Fraud Champion.
- The national ESR fraud awareness e-Learning module has been implemented by the Trust. Mandatory training for staff went live in January 2021 and by year end more than 70% of all staff had completed the module. Bespoke fraud awareness presentations have also taken place with a number of staff groups across the organisation.
- Numerous local/national alerts, briefings and guidance have been circulated to staff members and departments to raise fraud awareness of current risks during the pandemic.
- The 2018/19 National Fraud Initiative (NFI) has been concluded. A briefing note was issued to the Trust setting out a summary in relation to the data matches, which were processed with no issues identified. The 2020/21 NFI exercise has commenced with the matches to be reviewed and processed by Finance and MIAA during 2021/22.
- A pro-active exercise has commenced in respect to bribery compliance at the Trust. A report will be submitted to the Audit and Risk Committee once the final information has been submitted by the Trust.
- It was reported that all referrals and queries from 2020/21 have all been processed with the exception of one case that remains open.
- *CFA Standards Rating* - Reference 2.4 has an amber rating. This relates to the Trust's declarations of interest compliance rate at the end of 2020/21. It was recognised that this area of work has progressed immensely due to the work that has taken place over the last twelve months; 2019/20 compliance was 59% and 2020/21 compliance is 78%. This standard has remained at amber as there are still 137 decision making staff who need to complete a declaration of interest. The Trust is looking to attain a green rating in 2021/22.

Resolved:
The Audit and Risk Committee received and approved the Anti-Fraud Annual Report 2020/21.

21/22/18 Anti-Fraud Plan for 2021/22

The Audit and Risk Committee received the Anti-Fraud Annual Work Plan for 2021/22 and was provided with an overview of the programme of work. The Committee was advised that the Plan includes core work that takes account of the NHS CFA's organisational strategy, including compliance with the new Counter Fraud Standard that replaced the existing CFA Standard as of the 1.4.21.

It has been proposed to conduct a local proactive exercise in respect to overtime during the pandemic, of which, the Committee will need to approve. It was reported that a discussion has taken place regarding this proposal and it was felt that it was a pragmatic thing to do as staff have been working alternative patterns therefore controls were different in 2020/21. The Chair queried as to whether the Committee would receive a report on this piece of work. It was confirmed that the Committee will receive an update on the outcome of the exercise and will also receive a summary of the Bribery Review during the next meeting.

Resolved:
The Audit and Risk Committee approve the Anti-Fraud Plan for 2021/22

21/22/19 E&Y Audit Planning Report for 2020/21

The Audit and Risk Committee received the External Audit Planning Report for 2020/21. The Committee was advised of the audit risks and areas of focus that the Plan will address. The following points were raised:

- *Accounting for joint ventures* – This risk has been left on the Plan as management expect increased activity in relation to hosted arrangements therefore Ernst and Young (E&Y) continue to view the Trust's relationship and reporting of subsidiaries/joint ventures as an inherent risk. It was reported that Ken Jones has been in consultation with Richard Tyler regarding this matter.
- *Valuation of land and buildings* – This year it has been proposed to undertake a desk top evaluation rather than a full evaluation in order to look at the basis of the valuation and the judgements that have been applied.
- *Going concern assessment and disclosures* – This was a significant risk in 2019/20 therefore E&Y will be reviewing this area of work in terms of management's assessment of cash flows and forward forecasting.
- *Value for money (VFM)* – Due to the changes in the Code of Audit Practice there is no longer overall evaluation criterion to conclude on. Instead, the 2020 Code requires the Auditor to design their work to provide them with sufficient assurance to enable them to report to the Trust a commentary against specified reporting criteria on the arrangements the Trust has in place to secure value for money through economic, efficient and effective use of its resources for the relevant period. The specific reporting criteria are financial sustainability, governance and improving economy, efficiency and effectiveness. Attention was drawn to page 14

of the report in respect to the considerations for planning and identifying VFM risks in relation to the work that E&Y are required to undertake.

The Chair asked for it to be noted that, as a result of the reporting deadline being deferred to the end of June, May's Audit and Risk Committee will be re-scheduled to the third week in June to accommodate this change.

The Chair queried as to whether the uncorrected misstatement from 2019/20 had been addressed. It was confirmed that it had been corrected during the course of the year. A request was made for discussions to commence in respect to going concern to ensure that this area of work is addressed in a timely manner. It was confirmed that discussions have already begun. The Chair advised the Committee that a report will be submitted to the July meeting on going concern along with the Financial Accounts to provide an explanation of the rationale and evaluation of the going concern judgement.

Resolved:
The Audit and Risk Committee received and noted the External Audit Planning Report for 2020/21.

21/22/20 Draft Annual Governance Statement 2020/21

The Chief Executive, Louise Shepherd, presented the draft Annual Governance Statement (AGS) for 2020/21 to the Committee. Attention was drawn to the extraordinary year that the Trust has had owing to the pandemic, and the way in which the organisation transformed processes to ensure it retained a strong sense of control around key issues. It was pointed out that this was thoughtfully done by the teams and supported by the Trust's Non-Executive Directors (NEDs) to enable a governance lite approach to be established for a substantial period of time. It was felt that the framework that was implemented ensured strong oversight and assurance.

The Committee was advised that the organisation's risk management process has improved immensely in 2020/21 with greater ownership of risks being taken on the frontline. Louise Shepherd paid tribute to NED colleagues who have been rigorous in respect to how the organisation manages its risks. Louise Shepherd referred to the substantial assurance provided by Internal Audit and commended the AGS to the Committee.

The Chair felt that the AGS reflects the work that has taken place during the year and felt that the organisation has made great strides in improving its risk management process.

Resolved:
The Audit and Risk Committee approved the Annual Governance Statement for 2020/21.

21/22/21 Draft Audit and Risk Committee Annual Report 2020/21
Resolved:
The Audit and Risk Committee received and approved the Audit and Risk Committee Annual Report.

21/22/22 Audit and Risk Committee Terms of Reference (ToR)

The Committee received the Audit and Risk Committee Terms of Reference. It was felt

that the ToR reflects the work that has taken place during its first six months, but it was pointed out that there may be some slight amendments following a review of the work conducted by the Committee and the Care Delivery Board.

Resolved:
The Committee received and approved the Audit and Risk Committee Terms of Reference.

21/22/23 Waiver Activity Report

The Committee received an update on the activity in relation to approved waiver requests for the period 1.4.20 to the 31.3.21. It was reported that due to the Covid-19 crisis there was a huge increase in waiver activity in 2020/21. It was pointed out that this was unavoidable due to the critical situation in respect of the requirement for Personal Protective Equipment (PPE). In terms of value, Covid-19 related purchases equated to c£7m of the £9.2m total waiver. The Committee was asked to note that £5.2m of the £7m was expenditure made by Alder Hey on behalf of the Cheshire and Merseyside region as the Trust took the lead on the procurement exercise in respect to the bulk purchases with Crown Salvage.

The Chair drew attention to the unusual circumstances that have been experienced as a result of the pandemic which accounts for the increase in waiver activity and a wider spend.

Resolved:
The Audit and Risk Committee received and noted the Waiver Activity End Year Report for 2020/21.

21/22/24 Progress against actions from the Audit and Risk Committee Self-Assessment

The Committee was provided with an update on the progress against the actions from the Audit and Risk Committee self-assessment. It was reported that the majority of the actions are underway and in the process of being addressed, with many being completed in the next quarter. Following the review of the Committee and the Care Delivery Board a large number of the actions will become the remit of the Care Delivery Board.

Resolved:
The Audit and Risk Committee noted the progress against the actions to date.

21/22/25 Sources of Assurance

The Chair opened up a conversation around the assurance reports that the Committee receives and queried as to whether there are any other areas of work that the Committee doesn't receive information on that would provide assurance.

Following discussion feedback was provided by members and it was felt that some of the main areas of assurance that should feed into the Committee are; Clinical Audit and reporting, Information Governance, Data Protection, Data Quality, Cyber Security, Freedom of Information and Third-Party Assurance.

It was concluded that a proposal will be submitted during September's meeting to agree the additional areas of work that will feed into the Audit and Risk Committee, in terms of assurance.

21/22/25.1 Action: KB/ES

21/22/26 Any Other Business

External Audit Extension and Fees for 2020/21

It was reported that the initial contract for external audit services has been in place since 2017 with an original contract end date of the 31.8.20. This original contract included two one-year extension options available to the Trust which it decided to invoke simultaneously thus extending the current arrangements to the 31.8.22. Prior to the formal issuing of this extension, Ernst and Young (E&Y) notified the Trust of its intention to increase the fee rate to £70k plus V.A.T. per annum and provided rationale and justification for doing so. The Committee was advised that this increase in fees was never formally ratified by the Audit and Risk Committee.

Prior to commencement of the interim audit for 2020/21, recognising the next formal Audit and Risk Committee meeting wasn't due to take place until the 22.4.21 a meeting was held between John Grinnell, Ken Jones and the Committee Chair on the 12.4.21 in order to approve the increase in audit fees in line with the notification from E&Y and the contract extension notification issued by the Trust. Following consideration of the reasons presented by E&Y the increase was approved.

The Committee discussed the benchmarking of fees and the original procurement process that took place prior to agreeing a contract for external audit services. It was concluded that the Audit and Risk Committee will note this agreement in respect to the increase in fees and the extension of the external audit services through to the 31.8.22. It was also acknowledged that the Council of Governors would need to be briefed on this matter.

21/22/26.1 Action: JG

Resolved:
The Audit and Risk Committee noted the increase in fees that were agreed on the 12.4.21 and the extension of E&Y's services through to the 31.8.22.

21/22/27 Meeting Review

The Chair felt that the agenda was managed appropriately with each item receiving the right amount of time for discussion.

From a risk perspective, the Chair felt that a lot of work has been conducted to address the organisation's longstanding risks. The Care Delivery Board has also been instrumental in driving risk forward with increased engagement from Executives and Divisional Leads. It was pointed out that the Audit and Risk Committee is provided with information that enables members to offer challenge when necessary and the organisation has recently agreed its risk appetite statements. On behalf of the Committee, the Chair thanked all those involved in this great achievement which will be shared with the Trust Board.

Date and Time of the Next Meeting: Thursday 17th June, 2:00pm-3:30pm, via Teams.

Resources and Business Development Committee
Confirmed **Minutes of the meeting held on Monday 24th May at 10:00am, via Teams**

Present:	Ian Quinlan (Chair)	Non-Executive Director	(IQ)
	Shalni Arora	Non-Executive Director	(SA)
	Claire Dove	Non-Executive Director	(CD)
	Adam Bateman	Chief Operating Officer	(AB)
	Dani Jones (part)	Director of Strategy & Partnerships	(DJ)
	John Grinnell	Director of Finance	(JG)
	Melissa Swindell	Director of HR & OD	(MS)
	Kate Warriner (part)	Chief Digital & Information Officer	(KW)
In attendance:			
	Mark Flannagan	Director of Communications	(MF)
	Russell Gates	Associate Commercial Director Development	(RG)
	Ken Jones	Associate Director Financial Control & Assurance	(KJ)
	Cath Kilcoyne	Deputy Director Business Development	(CK)
	Rachel Lea	Deputy Director of Finance	(RL)
	Claire Liddy	Managing Director of Innovation	(CL)
	Andy McColl	Associate Chief Operating Officer, Surgery	(AMc)
	Nicki Murdock	Medical Director	(NM)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Clare Shelley	Associate Director Operational Finance	(CS)
	Amanda Graham	Committee Administrator (*minutes*)	(AG)

20/21/217 Apologies:
No apologies were recorded.

20/21/218 Minutes from the meeting held on 26th April 2021.

Resolved:
The minutes of the last meeting were approved as an accurate record.

20/21/219 Matters Arising and Action log
Capacity Lab – RL / RG to confirm attendance at June meeting
Green Plan – discussions being held offline (JG & MF)

20/21/220 Declarations of Interest
There were no declarations of interest.

20/21/221 Finance Report
Month 1
KJ presented the current financial position as at the end of Month 1. Discussions are still ongoing with the ICS & NHSI in relation to H1 planning and how the H1 position will develop. Currently the H1 plan excludes restoration & recovery costs and any income from Elective Recovery Fund (ERF) monies. The position at month end is £1.6m deficit which includes costs incurred for restoration & recovery. The overall C&M M1 performance is not yet known.

Cash balance is healthy and capital expenditure is £1m above plan this month, mainly related to accelerated spend on the Community Cluster and Dewi Jones building works; that will reverse in coming months.

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KW asked excluding additional recovery costs, is Surgery in balance and given challenges in division, there is a need to understand the underlying position. KJ responded that a large part is down to restoration but there are historic pressures that needed to be addressed. The division is progressing well in terms of recovery. AMc noted that while there is some remaining underlying risk within Surgery, this has been addressed in their annual plan for 2021; risks include junior doctors, cardiac standards and some of the management costs for the safe waiting list work being undertaken. IQ asked what the underlying position would have been without the restoration impact; KJ responded that it would be around £200k variance but there will be more detail in the paper later in the meeting.

IQ raised a point around the start-up costs were for the LLP; KJ replied that the costs shown are not start-up costs but are related to the increased activity being undertaken by the LLP. RL confirmed that the volume of sessions has been higher than pre-LLP, with greater take-up within Orthopaedics & Spinal.

AB noted that currently there is an imbalance between the costs of recovery & restoration against the expected ERF income and there may be a specific piece of work needed to ensure these are aligned. RL confirmed this and noted that currently this is focussed on expenditure. When system reporting and the H1 Plan are in place there will be a check against that and the C&M position overall so any income that would have been generated will be checked against the recovery costs and against the system. KJ noted that there is currently a risk of incurring recovery costs while also holding a risk of making the assumption of receiving ERF income and of that being incorrect when it does come through. RL added that currently indications show that C&M will meet the targets for ERF income and that will flow through.

JG noted that real clarity needs to be brought but currently things are quite uncertain with the baseline level of funding, the recovery already planned and now the paediatric accelerator programme. All the previous tracking mechanisms are being disrupted and a new funding envelope was received just at the end of last week. JG gave assurance that there is now a plan which can achieve break-even but also recognising that there is a lot of untangling to be done before any real clarity can be given to the Committee over the success factors.

Action: KJ to circulate detail on Surgery also a M1 'true' position with restoration costs and potential income shown separately (KJ)

Resolved:
RABD received and noted the M1 Finance report.

20/21/222 **2021/22 Annual Plan**

Draft Operational Plan
AB gave a brief overview of the Draft Operational Plan for 2021/22. The annual plan for 2021/22 is aligned to the national framework given as part of the COVID recovery response. The key element is the Brilliant Basics programme, comprising of 7 priorities which have a line from the executive summary through the strategic priorities and down to driver metrics.

Financial Framework
RL presented a brief outline of the financial element of the Operational Plan. An activity submission has been submitted to C&M showing a trajectory for April to September for outpatient and elective, which has been used by the divisions to

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demonstrate where capacity can be added to increase activity. This has enabled modelling of the ERF income against delivery cost. Currently indicating that C&M will hit the targets as a system, thus unlocking the ERF monies. Bids have also been submitted to the Paediatric Accelerator Programme, focussing on 5 hotspot specialities.

RL gave an overview of the revised Financial Framework for 2021/22, sharing the detail of the late guidance and its impact. Initially the Plan was based on assumptions of system funding but assumptions of ERF monies had not been included, giving an H1 deficit of £3.6m. The most recent changes have come from a change to the methodology and has resulted in three fundamental changes: a re-evaluation in system funding to all providers resulting in a drop of £2.6m for Alder Hey; a system-wide efficiency target of 1.25% given to all providers equating to £1.9m for AH and a further £400k of costs not being recognised which increases efficiency to £2.2m; finally there is an assumption that the £4m projected ERF contribution will materialise. Risk remain regarding delivery of efficiencies and activity recovery and also C&M delivering overall as a system.

IQ asked whether the £2.2m efficiencies is CIP by another name; RL replied that it is, and involves reducing costs further, taking opportunities to increase activity & raise the ERF income and reducing base costs. It is a huge challenge as there had been an amount of money for a number of business case which are now paused along with new investments and these will potentially need to be remodelled and conversations need to be had in SDG around what investment can happen.

JG noted that work is ongoing across the system to keep control of delivery and a good flow of funds around the system. If the ERF monies can be secured that will stand us in good stead. A lot of effort is being expended on H1 and the focus needs to move to H2 and next year; ideally H1 could almost be locked in to allow focus to move to H2 and 22/23.

Paediatric Accelerator Bid
AB gave an overview of the national Paediatric Accelerator Bid programme which Alder Hey has committed to with other specialist Children's Trusts. The programme offers extra investment to improve access to care, with an approved bid of £15m (topped up to £20m when other centres are included). The collaboration between 5 specialist Children's Trusts has two strands to it: one is the short term necessity to treat more C&YP; the other is the 120% ambition overall through all our services. Measurables are likely to be in 5 specialities that can demonstrably achieve the 120% and long term the collaboration with the other Trusts can be worked on to build something special as a legacy offering long lasting and sustainable benefits to staff.

The specialities selected are those where there is an existing access issue, with the biggest numbers of C&YP waiting for treatment. Mutual aid across C&M forms part of the bid and this would mean other providers of C&YP services would be given an opportunity to access this additional capacity for their longest waits. Digital equipment is also included to increase F2F consultations as is an increase to ward capacity to manage both the expected RSV surge and increased elective care. Legacy around technology is being explored by the Innovation team and there is a part around staff support for long-term sustainability.

Action: Further detail on the Financial Plan to be given at next meeting (RL)
Action: Further detail on the Accelerator bid to be given at next meeting (AB)

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Resolved:
RABD received and noted a detailed update against the Draft 21/22 Operational Plan, 2021/22 Financial Framework and Paediatric Accelerator Bid.

20/21/223 **Surgery Action Plan update**

AMc gave an update on the Surgery action plan, noting the discussion earlier in the meeting around the variance and combination of restoration & recovery costs along with underlying pressures. The report provided shows current progress against the three areas of cost reduction. For pay expenditure, nurse bank spend has continued to reduce across wards and medical staff costs are reducing now some medical staff are back at work & undertaking clinical duties and cover is not being provided. As a service development, there has been a request submitted to NHSE for £1.8m for cranio-facial - commissioner queries have been responded to and a final decision is awaited. A further update along with detail on spend & activity delivered will be brought in two months.

IQ asked what the expected deficit will be for 2021/22; AMc responded that there is a large element of activity & income recovery, and cost pressures expected in excess of £1m which need to be resolved by cost reduction or increased Commissioner funding, but overall, it is expected to be around £1m deficit at year end.

Resolved:
RABD received and noted an update on the Surgery Action Plan.

20/21/224 **Alder Hey Ventures**

RL gave a brief update on the wholly-owned company Alder Hey Ventures and noted that the company has three registered directors at Companies House namely Louise Shepherd, Claire Liddy and David Powell but paperwork has now been completed to remove David Powell and appoint John Grinnell as the third director. Appropriate director's liability insurance is in place and the company is covered under the Trust's insurance. Advice has been sought from KPMG in relation to VAT and Corporation tax which is being actioned, along with previous advice provided to Innovation Committee around structure and setting up a subsidiary. Start-up funds for the transparent mask work of £30,000 will be injected, to be repaid on an SLA basis. Specific IP insurance will be put in place against any future IP claims. Further governance detail related to Alder Hey Ventures will be provided to a future meeting.

IQ noted that there are the same directors on both sides of the agreement with the Trust and Alder Hey Ventures; RL responded that other Trust directors would be used rather than those who are Alder Hey Ventures directors.

CL noted that there will be governance & reporting requirements for both Companies House and the Trust now the company is being activated which may require discussion with ES; it would also be appropriate in governance terms for Non-Executive Directors to be involved which will need formalising to give an appropriate level of assurance.

SA commented that there has been some loss of momentum with partnership agreements with the acorn companies being handed over from Innovation Committee; CL noted that those are on temporary hold until the new Associate Director of Commercial Finance is in post in July.

CL advised that progress has been ongoing with the transparent masks and the manufacturing company are looking at an 8-week timetable to have these ready for use. Currently there appear to be no strong competitors in the marketplace.

Action: Further discussion required around governance & reporting (CL/ES)
Action: NEDs to be appointed to AHV board for assurance (CL/ES)
Action: Actions from Innovation Committee relating to Acorn companies to be progressed in July (RL/CL)

Resolved:
RABD received and noted the update on Alder Hey Ventures.

(KW & DJ left the meeting)

20/21/225 **Capital & Cash Updates**

KJ outlined the ongoing capital programme and shared the projected allocations of capital funding, advising that there have been heavy challenges from NHSI and the ICS over the whole 5-year programme and this puts challenge in terms of meeting aspirations for our capital programme over the whole five years if those projected allocations become reality. Capital affordability challenges of a total of £20m have now been added to the capital programme previously shared, particularly for 2023/24 and 2024/25. Clarity is being sought from NHSI to enable planning to continue.

Currently the capital programme is running in line with last year's plan assuming approval & progression of the PAU development. Work is ongoing to find any opportunities in those years to push back and ease capital spend, particularly on year-to-year spend such as IT and medical equipment. Estates schemes are multi-year which makes planning more difficult with annual allocations. Transfer of CDEL allocation within the ICS is also being explored and considered to offset other Trusts less favourable cash positions.

KJ shared the current cash position and outlined an indicative 5-year forecast based on the projected capital allocations.

IQ asked whether the headroom illustrated is sufficient to run the hospital; KJ noted that it is believed so, as there has been a reduction in creditors over the last few years negating the need for a high cash balance and that has been built into the financial mapping. It will also depend upon how long block payments are in place.

NM asked what the underlying deficit figure comprises of; KJ responded that this is based on the projection for H1 of £6m savings to break even, carried forward across the five years.

CL noted that the savings illustrated are to achieve break-even and not to generate cash to do new things; also that currently there is no scope within the plan for investment and advancement in innovation & technology. RL commented that this is currently in draft, there will be further discussions and the proposed plan will need to come back to this committee and to Trust Board for agreement.

SA asked for information about what has been committed for the next two years and what is still up for discussion, there may need to be another look at what the money is spent on. It may not be building but digital technologies that further investment more than buildings would. KJ noted that there is information on what has been

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committed and that can be shared. Decisions are still to be made on the direction of travel for long term capital planning.

Resolved:
RABD received and noted the Cash and Capital updates.

20/21/226 **Campus & Park Updates**

RG gave an update on the progress of the campus development and park reinstatement, noting the demolition of the old boiler house chimney along with the management offices and the water tower is currently being demolished. Electrical works are ongoing for the new ED car park and work at Innovation Park is moving on with an anticipated occupation date of early August. Following a fire, the Knotty Ash Nursing Home has disrupted plans for vacating the remaining retained estate buildings and discussions are ongoing with loss adjusters and insurers regarding whether th building is salvageable or will need to be demolished.

In the Park, phase one is now complete and a formal handover date is awaited from the City Council. Work is ongoing to reduce the previously estimated costs for phases 2 and 3 but things are progressing with some cost reductions and reduced requirements for contamination remediation. Environmental consultants are very optimistic that the revised proposals should be acceptable. Sport England have requested a revised playing field strategy to support the City's statement that the football pitches are not required which is currently being worked up by the Council. As the pitches are in phase 3 this process can be allowed to play out until an expected conclusion towards the end of the year. Play equipment alternatives have been put forward to the Council for approval of a different type & manufacturer for the same quality which should show a cost saving. A detailed paper will be brought back to RABD next month for approval to progress to phase 2.

IQ asked how the costs are so different from the original budget projections; RG responded that it is believed that the original figures were based on a supposition of without actual cost estimates.

Resolved:
RABD received and noted the Campus & Park updates.

.20/21/227 **NEO / PAU Development Update**

RG presented a paper requesting approval to go out to tender w/c 24th May 2021 for the Neonates, EDU and PAU development. Design is now at stage 3 and is currently being signed off by both clinical stakeholders, PFI partners and IPC. The overall project budget is £18.6m; a tender estimate has come in with two late items giving a figure of £18.78,m a cost pressure of £120k. A contingency is still being held and there is confidence that the late changes can be absorbed within the budget of £18.6m if the project board approve them. Three companies on the NW Procurement Framework have been shortlisted to be issued with the tenders; contract has been agreed with Project Co to recognise the issues of delivery through the PFI. Once a contractor has been selected, the Trust will novate both the contractor and the design to Project Co for them to manage. If the PAU element is not finally approved, it will be withdrawn post-tender and prior to selection.

NM asked what the cost is for the ED carpark; RG responded that the cost would be around £200k, including moving the blue light road to accommodate the changes.

RL asked for clarification on whether tenders are being sent out with options for with and without the PAU; RG responded that the tenders will be going out with selected

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rates, giving visibility of the PAU element so in the event of the project not being approved it can be removed.

Resolved:
RABD received and noted the NEO / PAU Development update and approved the sending out of tenders to the selected companies.

20/21/228 **Marketing and Communications Update**
MF gave a verbal Marketing & Communications update, noting that discussions are ongoing with agency Strathouse working on the Alder Hey narrative and implementing the brand-led Communication strategy. More details will be brought to a future meeting.

Resolved:
RABD received and noted the Marketing & Communications update.

20/21/229 **Alder Hey Green Plan**
This item was withdrawn pending further work and will be brought to a future meeting.

20/21/230 **Month 1 Corporate Report**
AB presented an update on the M1 Corporate Report, noting as a highlight that in April 2021 more children & young people were treated than in April 2019, at 105%. Key challenges have been in ED with families struggling to access primary and community care thus increasing attendances to 110% and causing some families to wait over four hours for treatment. Work is ongoing with primary care providers and to put on more face to face appointments.

Resolved:
RABD received and noted the M1 Corporate report.

20/21/231 **Safe Waiting List Management Update**
AB gave a brief presentation on the Safe Waiting List Management program and updated the meeting that validation work is now complete for the inpatient waiting list, which is now live on Microsoft Power BI. Work is ongoing to validate the outpatient waiting list with only a small number to date waiting over 52 weeks and no harms have been discovered during clinical review of those. Work continues to evaluate and review the planned waiting lists with extra capacity being given to dentistry to offer their log waiters treatment dates. Regular monitoring meetings with the CCG continue to be held.

Resolved:
RABD received an update on Safe Waiting List Management.

20/21/232 **PFI Report**
The PFI Report for Month 1 was noted as being within the meeting pack for information.

Resolved:
RABD received and noted the M1 PFI report.

20/21/233 **Digital Update**
KW gave the Digital update, noting that assessment for HIMSS Level 7 will be in September 2021. There are currently challenges within the Alder Care Programme which are impacting the planned go-live but options are being worked upon with

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Meditech. The integration of services with LHCH is progressing; currently in the staff consultation phase with the TUPE expected w/c 31st May. Following a change in executive lead, a significant programme of work is progressing with the BI Information department and some of that has been included in the report from an assurance perspective and this will continue going forward. A large test piece of work has been undertaken with ED around mobile phone reception, the benefits of which will be reported back and then hopefully can progress rolling that out wider across the Trust.

Resolved:
RABD received and noted the Digital update for April 2021.

20/21/234 *(numbering error)*

20/21/235 **Board Assurance Framework**
ES gave an update on the Board Assurance Framework, noting that risks on the financial environment are very life and need regular updating. There will need to be conversations on the framing of the system risk following recent strategic discussions, not just financially but legislatively for the current year's documentation once process is complete.

Resolved:
RABD received and noted the BAF update for April 2021.

20/21/236 **Any Other Business**
There was no other business.

20/21/237 **Review of Meeting**
Key points: It appears that a smaller number of substantial issues are being discussed.

Date and Time of Next Meeting: Monday 21st June 2021, 10am – 12.30pm, via Teams.

Confirmed Safety and Quality Assurance Committee
Minutes of the meeting held on
Wednesday 19th May 2021
Via Microsoft Teams

Present:	Kerry Byrne	Non-Executive Director (Chair)	(KB)
	Dame Jo Williams	Trust Chair	(DJW)
	Nathan Askew	Chief Nursing Officer	(NA)
	Adam Bateman	Chief Operating Officer	(AB)
	Pauline Brown	Director of Nursing	(PB)
	Adrian Hughes	Deputy Medical Director	(AH)
	Robin Clout	Interim Deputy CIO	(RC)
	Lisa Cooper	Director - Community & Mental Health Division	(LC)
	Beatrice Larru	Consultant, Infectious Diseases	(BL)
	Phil O'Connor	Deputy Director of Nursing	(POC)
	Nicki Murdock	Medical Director	(NM)
	Jacqui Pointon	Associate Chief Nurse/Safety Lead	(JP)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Melissa Swindell	Director of HR & OD	(MS)
In attendance:			
	Julie Creevy	Executive Assistant (Minutes)	(JC)
	Rachael Hanger	Associate Chief Nurse, Surgery	(RH)
	Abby Peters	Associate Director, Strategy & Partnerships	(AP)
	Cathy Umbers	Associate Director of Nursing & Governance	(CU)
	Cathy Wardell	Associate Chief Nurse, Medicine Division	(CW)
21/22/27	Benedetta Pettorini	Consultant Paediatric Neurosurgeon, Lead of Quality Hub	(BP)
21/22/27	Jennie Williams	Head of Quality Hub	(JW)
21/22/28	Glenna Smith	EPR Programme Manager	(GSm)
21/22/28	Gerri Sefton	Advanced Nurse Practitioner for Critical Care	(GS)
21/22/28	James Ashton	Lead Sepsis Nurse	(JA)
21/22/35	Liz Edwards	Head of Clinical Audit & NICE Guidance	(LE)
21/22/38	Michelle Perrigo	Clinical Legal Services Manager	(MP)
21/21/23	**Apologies:**		
	Fiona Beveridge	(Chair) Non-Executive Director	(FB)
	Urmi Das	Interim Divisional Director for Medicine	(UD)
	John Grinnell	Director of Finance/Deputy Chief Executive	(JG)
	Dani Jones	Director of Strategy & Partnerships	(DJ)
	Alfie Bass	Divisional Director, Division of Surgery	(AB)
	Christopher Talbot	Safety Lead, Surgery Division	(CT)
	Kate Warriner	Chief Digital & Information Officer	(KW)

KB welcomed all members and attendees to the Safety and Quality Assurance Committee (SQAC).

21/22/24 Declarations of Interest

SQAC noted that there were no items to declare.

21/21/25 **Minutes of the previous meeting held on 21st April 2021 –**

Resolved: subject to minor drafting amendments to be made offline the committee members were content to **APPROVE** the minutes of the meeting held on 21st April 2021.

21/21/26 **Matters Arising and Action Log**

Action Log

The action log was updated accordingly.

Matters Arising

Complaints Action Plan

PB presented a comprehensive Complaints Action Plan, key issues as follows:-

- PB reported that complaints had moved to an electronic system of complaints management
- Complaints process had been fully reviewed
- A monthly Patient Experience Group had been established who would monitor the Complaints Action Plan.
- Complaints Action Plan progress is reported via CQSG and is monitored on a monthly basis, and through Quarterly Complaints Reports to SQAC.
- Quarter 4 full Complaints Report would be presented to June 2021 SQAC meeting, with comprehensive Complaint Action Plan incorporated within the quarterly report as an Appendix.

DJW thanked both NA & PB for the complaints update and alluded to the challenge regarding staff training, in terms of a cultural shift and referred to how professional judgement is exercised at an early stage for colleagues who are leading on complaints. PB stated that the review of the complaints structure is incorporated within the review of the complaints process, and that this is an area for review.

KB referred to the issue of monitoring. PB highlighted the importance of reporting on Ulysses and capturing information locally for the teams to address issues raised. KB referred to out of date phone numbers and a web form which are on the Trust website, and queried whether there is a need to review whether this could potentially be a more wider issue across the Trust. KB questioned whether the website maintenance process is appropriate and questioned whether this should be reviewed by RABD. ES advised that the Director of Comms is leading on significant work in terms of updating and enhancing the Trust website and advised that the Director of Comms is currently establishing a consultation and engagement process in terms of the website.

NA thanked PB for comprehensive Complaints Action Plan and highlighted the desire to develop a ‘one stop shop’ for the Trust to aid parents in having a central point of access and early resolution. The ongoing priority is regarding performance and improving responsiveness in terms of complaints.

KB thanked PB for update.

Resolved: SQAC received and **NOTED** the comprehensive Complaints Action Plan and **NOTED** the recommendations of the Plan. SQAC **NOTED** that

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SQAC would receive Quarterly Complaints Reports. SQAC **AGREED** to refer its concerns regarding website maintenance process to RABD for review and to provide subsequent assurance as to its effectiveness.

Neurology Action plan update
CW provided a verbal update regarding the Neurology Action Plan, key issues as follows:-

- CW confirmed that feedback had been provided to the Neurology Team with the team appraised of the Action Plan and any associated shared learning.
- Division had ongoing dialogue and communication with CCG to share learning.
- The new L2P appraisal process is more robust, training had commenced for appraisers and job planning process is being established, with ongoing work within the Division to populate Job Plans.
- Robust mechanisms are in place to ensure escalation process if colleagues have concerns

KB welcomed the update and advised that the consultant job planning process was being monitored through Audit and Risk Committee via outstanding internal audit recommendations. KB welcomed future changes and improvements following the Tics and Tourette's progress made.

NA highlighted the importance of receiving the full written Action Plan for the next meeting in order to provide assurance to Committee members.

Resolved:- SQAC to receive Neurology Action Plan and accompanying report detailing status against each action to its meeting on 23.6.21

KB thanked CW for Neurology Action Plan update.

Quality Improvement Progress Reports

21/22/27 **Quality Priorities Monthly Project Update**
BP presented the Quality Priorities Project Update, which provided an overview of progress to date, learning from RCA's, RAPID pathway, escalation of care for deteriorating patients, key issues as follows:-

- New pathway for deteriorating patients had been established in the Trust.
- BP advised that ongoing work is taking place to address medication errors, BP is working closely with the Pharmacy Team to establish an action plan to reduce medication errors, with a target to reduce them initially by 20%.
- A "Tenfold Errors" summit was held on 13th April 2021, with all emerging actions included within an action plan, currently on correct trajectory
- Parity of Esteem – JW provided a project overview of Parity of Esteem and provided an update on progress to date in terms of safety in relation to medication errors.

NA thanked the team for continued efforts to date. NA recommended that the Quality Priorities update be deferred from June 2021, meeting and would be presented at July 2021 SQAC meeting. NA advised that he would meet with the team, together with NM and KPMG offline to establish outcome, process and balancing metrics and baseline in order to provide assurance against the quality improvements which SQAC requires going forward.

KB thanked BP & JW for update and highlighted the importance of receiving future reports in a timely manner to enable the Committee members to review them in advance of committee meeting.

SQAC RECEIVED and **NOTED** the Quality Priorities Monthly Project update, SQAC **APPROVED** the recommendation to receive the update at the July SQAC meeting.

21/22//28 DETECT Update

G Sefton & G Smith presented DETECT update, which provided an overview of background detail, options, gaps and recommendations/next steps, key issues as follows:-

- Deterioration post DETECT research study is due to cease in September 2021.

  Having considered various options available to Alder Hey at the end of the study the proposal is that the long term digital solution was to replicate the functionality into the Meditech EPR (AlderC@are).

  In the interim the recommendation of the review was to extend system C: Care flow Vitals and Connect for a 12 month period whilst the AlderC@re solution is being developed.

  G Sefton advised that the Trust is continuing to see very good results with a reduction in children experiencing crucial deterioration by over 30% - with around 100 children per year who had been saved from a critical deterioration. On review of productivity there had been more than 1,800 bed days released across the year by preventing those critical deteriorations. G Sefton advised that the ongoing challenge remains that people see DETECT as a study, and highlighted the importance of embedding this across the organisation.

  DJW stated that the impact had been tremendous and expressed thanks to the team for significant progress to date. KB advised of the need to give some thought regarding how the reports are received and improvement are made from this study. KB fully supported the intention to present the Business Case to RABD and SQAC accepted the outputs from the workshop together with the recommendations made and the next steps.

  NA advised that he is happy to work with the team regarding transition between systems, and suggested that when the study comes to a natural conclusion in September 2021 the team to provides a formal update to Board, and that the reporting for both DETECT and Sepsis would then transition into the Deteriorating Patient Workstream reported to SQAC. DJW agreed with this planned approach to Trust Board.

  KB thanked G Smith & G Sefton for the DETECT update.

  Resolved: SQAC RECEIVED, and **NOTED** the DETECT update,
  SQAC **ACCEPTED** the outputs of the workshop and **NOTED** the recommendations/next steps

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Delivery of Outstanding Care - Safe

21/22/29 Never Event Report Update

NA provided an update on the Never Event; key issues as follows:-

- NA thanked colleagues within the Surgery Division with regards to the initial rapid Never Event Review which had been undertaken. There are a number of completed actions which are now contained within the Action Plan.
- NA confirmed that the Trust does have a process in place in terms of Action 7 – with regards to a Fair and Just Culture which is part of the Disciplinary Policy. NA advised that the revised Policy had been approved at People & Wellbeing Committee on 18th May 2021 and confirmed that this action would now be closed.
- Action 8 – Chief Nurse & Director of Nursing had reviewed a selection of policies. On review of the policies, it is very clear in terms of roles and responsibilities, that the Trust have provided assurance that the 2nd check is included within the Policy. NA advised that this action would be closed.
- RH referred to an action regarding the introduction of new checklist pre op check, which was part of WHO checklist; this had been separated out to ensure clear accountability and ownership.
- RH referred to the action regarding site marking, with new documentation included which is MPSA for site marking documentation, a double sign to indicate that the site mark has been checked, and ensuring a check at every step of the process, which follows the patient from pre op to post op, and is being managed and monitored appropriately, with feedback from audit due week commencing 24th May 2021.
- RCA Never Event – the Division have secured an external orthopaedic surgeon and an external anaesthetist who would support the review in order to provide external views on the Division's practice. The Orthopaedic Team are trialling a theatre governance day with juniors, and if successful, plan to roll out across specialties.

NA referred to Action 3, and advised that the first part of the action in terms of the stop before block is complete and the remainder of the action would require a 1 month extension, with the expectation that by 7th June 2021 that this action would be completed.

SQAC RECEIVED and **NOTED** the Never Event Report and **NOTED** the progress to date, SQAC to receive outcome of full RCA and associated action at June 2021 meeting.

DJW, welcomed the positive progress made to date, and queried whether this had assured the CQC. NA confirmed that the CQC had been sent the briefing paper and action plan, and that CQC had been satisfied, and had agreed that they would receive a further update at the CQC engagement meeting in early June 2021. NA advised that he is hopeful to provide a closed action plan to this meeting.

KB thanked NA for the Never Event Report update.

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21/22/30 CQC Action Plan

ES presented the CQC Action Plan, key issues as follows:-.
ES advised that the new Consent Policy is very robust and is extremely clear, with mental health capacity within a separate policy.

ES referred to a larger piece of work across the organisation to improve the consent process, with the need for open dialogue with CQC at the engagement meeting in June 2021 with regards to ongoing assurance, with the intention that, rather than have the CQC action log open for lengthy period, aim to have the policy signed off by June engagement meeting, to demonstrate improvement.

SQAC RECEIVED and **NOTED** the CQC Action Plan update.
KB thanked ES for update.

21/22/31 DIPC Exception Report

BL presented the DIPC Exception Report, key issues to highlight are as follows:-

- BL advised that there is ongoing work across the Trust in order to reduce CLABSIs.
- BL expressed concern that currently only 70% of staff had received 2nd dose of the covid vaccine. BL stated that this could relate to a data issue/anomaly and this is being investigated.
- Self-testing – the Trust had transitioned to the LAMP asymptomatic programme, and 3,444 tests had been undertaken with 2 positive cases.

KB referred to the HCAI Action Plan update and sought assurance from BL that the Plan update would be included in future DIPC reports. BL confirmed that this would be included in future DIPC reports.

SQAC RECEIVED and **NOTED** the DIPC Exception Report and **NOTED** the ongoing improvement required in order to ensure a sustained increase in 2nd dose Covid vaccination.

KB thanked BL for DIPC key issues highlight report.

21/22/32 SQAC metrics – Safer Staffing Report

CW presented the Safer Staffing Report, which provided an overview of staffing incidents, staff sickness, staff moves and NHSP data, key issues as follows:-

- There was a total of 30 green staffing days, with no Amber or Red days reported.
- It was noted that ED and Critical care were particularly busy during April, therefore staff were moved to support these areas when required.

NA queried whether there is a requirement for SQAC to receive the Safer Staffing Report at future SQAC meetings, NA would discuss offline with CW in order to ensure any Safer Staffing Report is relevant for SQAC Committee, NA would update SQAC following offline discussion with CW at June 2021 meeting.

Resolved: NA would undertake offline discussion with CW and would update committee members at June 2021 meeting.

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21/22/33 Emergency Department Mental Health Attendances: Quarter 4: 01January 2021 – 31 March 2021

LC presented the Quarter 4 MH Attendances at ED, which provided an overview of mental health attendances and detailed actions identified in Quarter 1, issues are detailed as follows:-

- 182 children and young people attended the Emergency Department with mental health concerns (an increase of 15% since Q3) The Trust's Crisis Care Service was contacted in relation to 153 cases;. this is an increase compared to Q3 of 68% and demonstrates an increase in use of the Crisis Care Pathway by the Trust's Emergency Department. This reflects the significant training and support provided to the Emergency Department staff to support children and young people presenting in mental health crisis.
- SQAC **NOTED** the Actions identified in Quarter 1 which included continued monthly meetings between the Crisis Care Service, Emergency Department and Ward 4C to review the current pathway and share monthly audit findings, continued daily presence of the Crisis Care Service within the Emergency Department, a monthly audit of 10 randomly selected cases to be undertaken by the Crisis Care Service to review the pathway which would be presented to Community & Mental Health Divisional Board. The Community & Mental Health Division is supporting the development of a digital dashboard to support regular audit, monitoring and sharing of information across the organisation.

KB welcomed the physical presence within ED and queried whether future reporting could demonstrate the complexities and challenges of the children and young people. LC advised that it would not be possible to include the data, and advised that there is a continued increase in the complexity of patients who are attending ED who require admitting to either surgical or medical wards. LC advised that the report would continue to evolve and would continue to be presented to SQAC. SQAC acknowledged that the report required ownership from ED/Medical Division. NA welcomed Quarter 1 future report and suggested that it be written by the Medical Division to ensure ownership from ED team.

Resolved: SQAC received and **NOTED** the Emergency Department Mental Health Attendances for Quarter 4, and noted the continued increase in ED attendances. SQAC welcomed the suggestion that the Quarter 1 Report be written by the Medical Division. KB thanked LC for update.

Effective

21/22/34 CQSG Key Issues Report

NA advised that the CQSG had focussed on non-compliance of policies and guidelines. the Task and Finish Group continued to meet fortnightly chaired by NA, with significant progress made to date. There are currently 75 policies and guidelines not in date, with plans for the majority to be within date by the end of May 2021.

SQAC RECEIVED and **NOTED** the verbal SQAC CQSG Key issues Update
KB thanked NA for CQSG verbal update.

21/22/35 NICE Compliance Report

LE provided NICE Guidance position statement, key issues as follows:-

- LE advised that there would be guidelines that would not be relevant to child health.

- NICE publications - the Trust had received 99 guidance documents from 2015 onwards.
- From January – April 2021 there were 5 new guidelines published that were applicable to the Trust.
- For the review period between January 2015 to April 2021, the report shows that overall compliance currently stands at 69% for Medicine, 77% for Surgery and 54% for Community, which could be considered as limited assurance with slow progress made to date.
- LE advised that Divisions had been requested to undertake a data validation exercise, in order to escalate internally.
- CQSG to ensure progress is monitored, to ensure all Divisions are sighted on timeframes and escalation.

DJW highlighted the importance of using clear/correct terminology/when describing the interpretation of guidance.

KB referred to cultural issues that may be underlying the non-compliance and proposed that SQAC receives a formal Action Plan detailing recommendations and clear timeframes and progress made, in order for SQAC to have oversight of the position. NA confirmed that CU would lead on this, in order to foster partnerships within Divisions and will ensure an Action Plan is presented to SQAC in July.

SQAC RECEIVED the NICE Report and **NOTED** the recommendations within the report in order to improve the current position, SQAC to receive an update on position in July***.***

21/22/36 Board Assurance Framework

NA presented the Board Assurance Framework on behalf of ES; key issues as follows:-

- NA advised that SQAC had received comprehensive update on Risk 1.1 regarding *'the inability to deliver safe and high quality services'* at its May 2021 SQAC meeting.
- Risk 1.2 – *'Inability to delivery accessible services to patients, in line with national standards, due to the adverse impact of COVID 19 on waiting times for elective care'* – NA advised that the Trust waiting times continue to increase, and that this risk had not changed.

SQAC **RECEIVED** and **NOTED** the Board Assurance Framework

KB thanked NA for update.

21/22/37 Divisional Reports by exception/Quality Metrics

Community & Mental Health Division – LC provided key issues as follows:-

Highlights

- LC advised that the electronic system regarding prescriptions went live on 6th April, which had resulted in prescriptions being sent directly to the pharmacy. This has resulted in an improved position; there had been 2 incidents reported related to lost prescriptions both of which related to Boots Pharmacy who had lost the prescriptions.
- Friends & Family test responses remain over 90% for Community & Mental Health Division
- The Community & Mental Health Division had received an overwhelming number of applications for posts advertised within the Division following recent Mental Health coverage which had been aired by BBC North West.

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Challenges

- Community & Mental Health Division continue to see an increase in referrals for mental health services – resulting in an increase of 30% of referrals
- Community & Mental Health Division continue to address the increasing level of complexity of patients within the Division.
- Continued increase in referrals relating to ASD & ADHD, which had been escalated to CCG.

Medicine Division – CW provided an update on key issues as follows:-
Highlights

- CW advised that delivery of mental health training? across 4C and ED had been successful
- Significant progress had been made regarding mental health training
- Section 31,the Task and Finish Group is working with the Programme Board to ensure a robust pathway and support groups are available for staff, with ongoing continued work.
- Divisional leadership and engagement session had proved successful for medical staff? and AHP's, with a quarterly divisional newsletter for staff, with weekly Q&A sessions for staff.

Challenges

- ED attendances remain a challenge with 283 attendances noted in May, with continuation of over 200 attendances noted. There are ongoing issues to address social distancing.
- There had been an increase in complaints during March with 12 complaints received relating to Neurology & ED. The Division are continuing to focus on responding within the 25 day timeframe, with very complex complaints.

  NA advised that colleagues are continuing to review options for providing a robust service in ED. Significant work is taking place with ongoing discussions required in terms of longer term support.

DJW expressed thanks to ED staff and Divisions for ongoing dedicated support and highlighted the importance of ensuring patients know that GP surgery practices are open and patients are signposted as appropriate, and highlighted the need to ensure this is shared with the 'system' in order to communicate to the wider community. Committee members recognised the challenge internally regarding keeping colleagues updated and informed.

KB queried how the ED position would be monitored by SQAC, and whether this would be a quarterly or monthly update. NA advised the Medicine Division could include an update at the end of each quarter. KB welcomed this proposal.

Resolved: SQAC to receive ED quarterly update report (requirement to be added to SQAC Workplan.

Surgery Division – RH provided an update on key issues, as follows:-
Highlights

- RH reported that the new governance processes within the division are becoming well embedded in terms of the twice weekly rapid review meetings
- Launch of the Johnson Baby products for the NICU newbuild had taken place which had helped raise awareness for the new unit.
- The Division are delighted with the Never Event response progress made

Challenges

- RTT position, despite ongoing efforts to improve this position, there are still ongoing challenges in terms of capacity for outpatients and inpatients, impacted with Covid restrictions; however the Division had seen an increase in theatre utilisation against 19/20.
- The Division are continuing to experience issues regarding medication errors, and the team are working closely with B Petteroni in terms of quality improvements regarding medication safety.
- Challenge for the Division with regards to Sepsis compliance and achieving the administration of antibiotics within the 1 hour time period. The Division are working with J Ashton to review individual cases to consider rapid response review to prevent this happening in other areas.

KB welcomed Divisional updates and thanked colleagues for updates.
SQAC RECEIVED and **NOTED** Divisional updates.

21/22/38 Policy Approval

Claims Policy – SQAC RECEIVED & RATIFIED the Claims Policy.

Document Control Policy – SQAC RECEIVED & RATIFIED the Document Control Policy.

Resolved: SQAC **RECEIVED** and **RATIFIED** the Claims Policy & the Document Control Policy.

21/22/39 Any other business

None

21/22/40 Review of meeting

- KB advised that the Committee had reviewed some comprehensive agenda items.
- KB welcomed positive update regarding Complaints Action Plan
- KB welcomed continued progress regarding DETECT update.
- KB welcomed ongoing progress regarding Never Event Action Plan
- High level of MH attendance and reliance on Crisis Care Team was NOTED by Committee
- BAF Risk -1.3 'Keeping Children, young people families and staff safe during COVID' – SQAC will recommend that Trust Board undertakes a 'deep dive/review' in August/September 2021
- Ongoing work is required regarding NICE compliance in order to ensure an improved position.
- Website maintenance process to be referred to RABD for review an assurance to as to its effectiveness to be provided.

20/21/40 Date and Time of Next meeting

23rd June 2021 at 9.30 via Microsoft Teams

Innovation Committee

Confirmed Minutes of the meeting held on **Monday 19th April 2021**

Via Microsoft Teams

Present:	Mrs. S. Arora	Non-Executive Director (Chair)	(SA)
	Mrs. C Liddy	Managing Director of Innovation	(CL)
	Dr. F Marston	Non-Executive Director	(FM)
	Mr. I. Hennessey	Clinical Director of Innovation	(IH)
In Attendance:	Mr. R. Clout	Deputy Chief Digital Information Officer	(RC)
	Mr. J. Corner	Digital Salford (External Advisor)	(JC)
	Mr. M. D'Abbadie	MSIF (External Advisor)	(MDA)
	Mr. J. Grinnell	Director of Finance/Deputy CEO	(JG)
	Mr. J. Hague	External Advisor.	(JH)
	Mrs. E. Hughes	Deputy Managing Director of Innovation	(EH)
	Ms. A. Lamb	Programme Director for Health Liverpool Innovation	(AL)
	Ms. R. Lea	Deputy Director of Finance	(RL)
	Mrs. K. McKeown	Committee Administrator	(KMC)
	Mr. I. Quinlan	Non-Executive Director	(IQ)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
Observing	Mr. J. Chester	Director of Research	(JC)
Item 21/22/06	Mr. J. Hoddinott	Tektology	(JH)
	Mr. K. Bell	AI HQ Team	(KB)
	Mr. D. Gates	AI HQ Team	(DG)
	Mr. J. Wrench	AI HQ Team/Innovation Consultant	(JW)
Item 21/22/11	Mr. J. Wrench	AI HQ Team/Innovation Consultant	(JW)
Apologies:	Ms. J. Blair (JB)	Acting Director of Research	(JB)
	Prof. I. Buchan	External Advisor	(IB)
	Mr. M. Flannagan	Director of Communications	(MF)
	Mr. R. Guerrero	Clinical Director of Innovation and Consultant Congenital Cardiac Surgeon	(RG)
	Dr. N. Murdock	Medical Director	(NM)
	Mr. D. Powell	Development Director	(DP)
	Mrs. L. Shepherd	Chief Executive	(LS)
	Mrs. K. Warriner	Chief Information Officer	(KW)

21/22/01 Apologies

The Chair noted the apologies that were received.

21/22/02 Declarations of Interest

The Innovation Committee noted the declaration received from Fiona Marston in relation to her association with the Liverpool School of Tropical Medicine.

21/22/03 Minutes from the Meeting held on the 8th February 2021
Resolved:
The minutes from the meeting that took place on the 8.2.21 were agreed as an accurate record of the meeting .

21/22/04 Matters Arising and Action Log

Action 20/21/37.1: *Health Tech Seed Fund Proposal (Provide a more detailed report on the Health Tech Seed Fund to enable a decision to be made about progressing the proposal)* – A meeting is scheduled to take place w/c 19.4.21 with the directors of MSIF to shape the Health Tech Seed Fund proposal. An update will be provided during June's meeting. **ACTION TO REMAIN OPEN**

Action 20/21/39.1: *Board Assurance Framework (A review of the Board Assurance Framework (BAF) is to take place prior to December's meeting. Incorporate the new commercial and clinical risks in December's BAF)* – This action has been completed. **ACTION CLOSED**

Action 20/21/50.2: *Business Developments/Partnership (Alliance Framework Agreement to be incorporated as part of the Trust's standard documentation)* – This action has been completed. **ACTION CLOSED**

Action 20/21/62.1: *Innovation Strategy Discussion Update (Submit the final version of the Innovation Strategy to the Committee during April's meeting)* – An update on the Innovation Strategy has been included on April's agenda. **ACTION TO REMAIN OPEN**

Action 20/21/63.1: *Innovation Performance Report (Provide the Committee with an update on the meeting that is taking place regarding the development of the Transparent Type 11 R Clear mask and provide additional information that was requested to help the Committee understand the wider commercial strategy for this product, for example, the extent of the market, opportunities, plans for international rollout/international partners, etc. It was agreed to provide the Committee with an update on the 19.4.21)* – This item has been included on the agenda. **ACTION CLOSED**

21/22/05 Draft Innovation Committee Annual Report – 2020/21
Resolved:
The Committee received and approved the Innovation Committee Annual Report for 2020/21.

21/22/06 Alder Hey Ai Strategy Road Map

The Committee received an overview of Alder Hey's Artificial Intelligence Strategy (AI) from John Hoddinott from Tektology. Information was provided on the following areas:

- What is AI; the opportunities and journey so far.
- AI at Alder Hey.
- Enabling governance in an AI environment.
- Capability.
- Data; data architecture, aligning to Data Mesh Principles and data availability.
- Ecosystems and Partners.

- Nine initiatives for a successful AI program

John Hoddinott responded to questions that were raised around the difficulties of implementing AI in a health setting versus digital marketing/transport in terms of the complexities around data security and governance, along with Alder Hey's role in the use of synthetic/anonymised data sets for diagnostics and future research. A discussion also took place in respect to accessing the Trust's data, its positioning in the strategy and the approach that is being taken to solve business/clinical challenges via the use of AI which it is felt will build the medium to long-term pipeline. Claire Liddy advised the Committee that the Innovation Team and the Digital Team will be working together to build data strategy into processes.

The AI HQ Team submitted a number of slides to advise on what has been done with the strategy and how the findings will be implemented. The following information was shared with the Committee:

- It was reported that the AIHQ sits within the Innovation Team as part of the Programme House and fits into the Artificial Intelligence/Health-Tech specialist group with the theme being around data.
- The AIHQ Team structure.
- The Team's vision and mission.
- The AIHQ offer (*new capabilities for the Trust*):
  - In-house team of experts.
  - Hyper Automation Toolkit.
  - Data platform for AI.
  - Partner validation and co-creation.
- AIHQ – Why?
  - Clinical outcomes *(Improve outcomes for individuals and groups of patients).*
  - Quality and safety *(Reduce serious untoward incidents, minimise harm and remove never events).*
  - Access to care *(Equitable, timely, appropriate and convenient access to services from anywhere).*
  - Patient centred services *(Personalised care with patient, family and carer participation).*
  - Optimisation and experience *(Release more clinical time to care and improve efficiency).*
- Current state.
- Objectives for the next 6 months.
- Future AI Road Map.
- Governance.
- Opportunities and Partnerships.

A discussion took place around the source of funding and the money that has been invested to establish Alder Hey's AI HQ, and attention was drawn to the importance of having a financial model that is scalable in order to progress and achieve the outcomes that the Trust is wanting. It was felt that further work is required to address the scale of investment versus the return. Claire Liddy reported that there is a significant amount of money being ploughed into AI as a result of the Government's Industrial Strategy and the plans for the Department of Health but it was pointed out that before the Trust is able to access the larger funding streams it will need to establish itself as a credible player,

therefore Alder Hey's present goal is to commence with this area of work and prove itself as an integral contender.

The Chair queried the overlaps between the AI strategy and the Trust's Digital Strategy and asked as to how they will be managed. It was reported that work is taking place to address this matter.

The Chair thanked John Hoddinott and the Trust's AI HQ team for the presentations and confirmed that the Committee will receive an AI HQ update on a quarterly basis. The Chair asked for this item to be incorporated in the work plan.

21/22/06.1 **Action: KMC**

Resolved:
The Innovation Committee received and noted the Alder Hey Ai Strategy Road Map update.

21/22/07 **Innovation Strategy Update**

The Committee was refreshed on the three key activities of the first phase of the 2030 Innovation Strategy deployment plan; position the Alder Hey Innovation Centre and its vision as a recognised Liverpool City Region Innovation Asset, lock-in a partnership ecosystem with Liverpool City Region as the anchor, establish a thriving pipeline.

It was reported that the Liverpool City Region (LCR) has established Project Boom which is a multi-sector proposition that will grow the levels of R&D investment into the city region. The Infection Innovation Consortium (IcoN) which is hosted by the Liverpool School of Tropical Medicine is the exemplar blueprint that sets out the standard for a successful innovation consortium. IcoN has raised £18m of public funding and has achieved a resource budget of £175m via the private sector.

The Committee was advised that discussions have been taking place between the Trust and colleagues in the city region about whether Alder Hey's Innovation Strategy and its key research question could follow in the footsteps of the IcoN project. Feedback from stakeholders has been positive and it is believed that the Trust may have an opportunity to be part of the Boom Programme, with the advancing child health element of the strategy being a fast follower to the Icon project. Attention was drawn to the benefits of the programme and it was reported that Alder Hey has positioned the Innovation Centre as a candidate for one of the four projects which is being warmly received by the Combined Authority and the Lead for Boom. The next stage of the process is to compile a proposal in readiness for submission to the City Metro Mayer in May 2021 and the Investment Panel in June 2021.

Jon Hague informed the Committee of the three 3 main constituents of Project Boom; 1. This is about the connectivity across the city region to enable all of the various contenders to access the programme. 2. Extending Liverpool Ventures to be more than just a health venturing innovation capability. 3. Looking at how the city can acquire more IcoNs. Attention was drawn to a fourth strand that Jonathan Hague is looking to build into Boom which looks at the use of, for example, Alder Hey as an exemplar for building a place-based Innovation Centre

Resolved:
The Innovation Committee received and noted the Innovation Strategy update.

21/22/08 Innovation Performance Report

The Committee was provided with an update on performance for the period from the 1.1.21 to the 31.3.21. Information on the following areas was shared:

- *Innovation KPI's* - Commercial revenue and agreements have been incorporated in the KPIs for innovation. It was reported that figures will start to increase as the Innovation Centre commences to expand its licences.
- Impact to Care Focus Case Study *(Immersive: VR Dog)* – The next steps will be to address intellectual property.
- Brand and Reputation
  - The Innovation Centre has presented at eleven events, are members of the UK Healthcare Pavilion and joined the UK International Healthcare Management Association.
  - The AI HQ was featured on Microsoft social media.
  - There has been a feature on Giant Health TV (*episode on Health Innovators*).
  - The Innovation Centre has increased impressions on social media by 300%
- Brand Positioning.
- Funding.

Resolved:
The Innovation Committee noted the Innovation Performance Report.

21/22/09 Health Innovation Liverpool (HIL) Update

Amanda Lamb provided an overview of the three main areas that HIL has been focussing on recently; **1.** ***Positioning on Global Health*** - It was reported that HIL is pursuing a major piece of work around global health. Part of the remit will be to support one of the major initiatives that the city region is submitting in September 2021. This work will look towards achieving maximum benefit from the asymptomatic testing that's been taking place across the city region, increasing capability and capacity in particular areas of interest and ensuring that the right analytics in AI capability are in place. **2.** ***Investment*** – HIL has been looking at ways in which to invest to create some sustainability for these capabilities once they are up and running, whilst acknowledging that public sector funding is particularly challenging in the global health space. HIL is looking to have a broader base for its investment portfolio and therefore has commenced discussions with private investors. These discussions are at different stages of progression and all are subject to commercial confidentiality agreements. **3.** ***Imaging Data*** – Discussions are taking place around the potential of developing an Imaging Data Strategy that will provide leverage not only for Alder Hey but across the wider footprint. It is necessary to consider the type and sources of data that need to be aggregated to progress this work therefore HIL are looking at liaising with Civic Data Co-operative (CDC) to draw together some of those additional resources that could be useful.

Claire Liddy advised the Committee that the Innovation Centre are working closely with HIL on the development of a Data Imaging Strategy and a further meeting is taking place this week.

Resolved:
The Innovation Committee noted the Health Innovation Liverpool update.

21/22/10 Business Development/Partnerships Update

The Committee was provided with a number of slides that provided information on Alder Hey's innovation partnerships. Information was shared on the following areas:

- Partnerships for strategy deployment.
- Objectives for the session:
  - Partnership methodology.
  - Definition and selection criteria and the Alder Hey 'ask'.
  - Next steps timetable.
- Advancing child health via a consortium.
- Alder Hey innovation eco-system offering.
- Strategic partner criteria and the ask.
- Discovery Programme partnership criteria and the ask.
- Project partner criteria and the ask.
- Next steps.

A discussion took place around SMEs in respect to the clarity of Alder Hey's role, the expected outcomes of the partnerships and the due diligence that is taking place when choosing partners. It was reported that the Trust has been very clear with SME partners that Alder Hey is not a route to investment but is a front door to a live hospital and support will be provided in respect to strengthening their business model/portfolio and developing their technology in terms of validating it in a healthcare setting. The Chair queried as to whether the Innovation Centre has research agreements in place for the partners that it is working with. It was confirmed that a number of protocols have been drafted and some partnerships are at the Heads of Terms stage.

Fiona Marston felt that receiving information on partnerships in a different format with a triage process incorporated would address concerns and provide the Committee with assurance that it is selecting the right partners for the organisation. Fiona Marston pointed out that partnerships are about complimentary expertise and being strong together along with benefits/outcomes and felt that having sight of this information would help the Committee, Resource and Business Development Committee (RABD) and the Trust Board support the Innovation Centre with the work it's trying to progress to build partnerships and a pipeline.

The Chair suggested reviewing the Commercial Partnership Agreement schedule with the view to making it more user friendly for the Innovation Committee and RABD. It was also felt that additional information should be incorporated in terms of governance and risk to provide further assurance. It was agreed that a meeting should take place to discuss this matter.

21/22/10.1 Action: CL/EH/SA/FM/ES

21/22/11 Transparent Mask Position Statements

The Committee was provided with an overview of the successful project that has taken

place to design a clinically validated transparent mask that has the potential to be commercialised.

Resolved:
The Innovation Committee noted the transparent mask position statement.

21/22/12 **Commercial Partnership Agreement Schedule**
Resolved:
The Innovation Committee received and noted the Commercial Partnership Agreement schedule.

21/22/13 **Rapid Prototyping Centre (RPC) Update**

The Committee received the RPC Progress Report for April 2021. An update was received on the following areas of work:

- The development and progress of the RPC mask.
- It was reported that the Innovation Centre is currently looking at the use of reusable materials for the production of masks in order to make them more disposable. Work is also taking place to look at a modular personal protection system for staff that will cover not only the head but the chest and legs.
- It was confirmed that the project relating to ID bracelets for babies has been put on hold for the present time.
- Work is taking place with a local company on a clear visa that has no reflection.
- Other areas of focus:
    - Space prototyping for the new Neonatal Unit.
    - Vascular access simulator to support staff training.
    - 3D Models for practising on prior to operating.
    - Wearable sensors for staff to predict fatigue.
- There have been 39 protypes ran through the Prototype Centre of which 12 have been successful and a third are in progress.
- Next steps:
    - Physical update for RPC.
    - Resident intern engineer/designer.

Resolved:
The Innovation Committee received and noted the Rapid Prototyping Progress Report.

21/22/14 **Board Assurance Framework Update**

The Committee received and noted the contents of the BAF for March 2021. Attention was drawn to the importance of articulating the risks relating to data protection in terms of AI, and the consistent reporting/tracking of partnerships. It was agreed that a meeting should take place following the Trust Board Strategy Session to discuss the data protection risk.

21/22/14.1 **Action: CL/ES**

21/22/15 **Any Other Business**

There was none to discuss.

21/22/16 Review of Meeting

The Trust's new Director of Research, John Chester, felt that the meeting was absolutely fascinating and the presentations were very informative. It was confirmed that John Chester will become a member of the Committee following his commencement in post in July 2021.

Date and Time of the Next Meeting: Monday the 14th of June, 1:00pm-4:00pm, via Teams.